11-05724 Kevin Akinfeleve

1-05724		Places Type or Print in Plack Indellate Int.	Enguna All Co.	-lee Aue I ear	2011	25501
evin Akinfeley	/e	Please Type or Print in Black Indelible Ink. E State of Maryland / Department of Hea			ible.	
5 1		1- For State Certificate of Dea Registrar 1. Decedent's Name (First, Middle,Last)	th		g. No.	
Physic ledical Exam			KINFELEYE	2. Date of Death Month July 31, 20	Dav Year	3. Time of Death 0433 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of De		4c. County of Death	
and the second		Southern Maryland Hospital Clint 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Uny		lo Di coldi	Prince George	
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und Mont	der 1 Year If Under 24 ths Days Hours	Min. APRIL 9	(MM/DD/YYYY) 9. Bird Foreig Cor	n NEW JERSEY
h		Usual Residence of Decedent				
d bow any		10a. State 10b. County 10c. City, Town or Location MD PRINCE GEORGE S LANHAM				10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show	Director		p Code	100	g. Citizen of What Cour	
ith the Maryland 23a or 28a-f sho notified at once.	ij	5634 WHITFIELD CHAPEL ROAD #304 2	20706	υ	SA	
death with or items 2		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent I VI Never Married 2 Married Armed Forces? 15 Yes, specific Forces 15 Yes, specific Forces 2 Married Armed Forces 2 Married Armed Forces 2 Married 15 Yes, specific Forces 2 Marri	ent of Hispanic Origin? ify Cuban, Mexican, Pu		14. Race - Ameri White, etc.	can Indian, Black,
ufter de ul", or i	y Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	No specify:		Specify: BLA	CK
hours a natura Exami	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of wo	Occupation (Give kind		16b. Kind of 8usiness/li	ndustry
11215-0036 Id be filed within 72 how dental Hygiene. 1121ked other than "na event, the Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) WAREHOUSE	· ·		PRIVATE	
5-0036 led within 7' Hygiene. lother than		17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	o Be	ISAAC S. AKINFELEYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address		BUNMI T. A		
_ 2 P 3 #	<u>ا</u>		S (Street and Number			1
re, MD s 1 and 2 sh of Health an of item 27 i		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nature of Disposition)	me of cemetery,		20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: RESURRECTION			CLINTON, MA	
Balti permit. Departm Importa			Address of Facility J			Talenta Controller
Physician		7474] 23a. Part I. Eyler the disease, or complications that caused the death. Do not enter the mode failure /List only one cause on each line.	ANDOVER RO. of dying, such as cardia	AD HYATTSV c or respiratory arres	TLLE, MARYL t, shock, or heart	Approximate Interval
/Medical examiner		Immediate Cause (Final disease a. Drowning				8etween Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ed sit	xaminer	events resulting in death) Last C. Due to (or as a consequence of):				
	calE	d. MENDED AMENDED 23a, 27, 28a-f, per me	σ918 8 – 11 –	11 cm		
	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	,g910 0-11-	11 5111	23d. Date of delivery	
Box 68760, e death certificate be the attending physical for use as the but	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death	3 Ectopic pres	gnancy		ay Year
Box e death the atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Spec	cify)	· · · · · · · · · · · · · · · · · · ·		
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	-	acco use contribute to the	_
ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.				- 24a. Was an	2 ✓ No 3 Proba	ably 4 Unknown ppsy findings available
e law r e has b ge 2 sh	Completed			autopsy performe	prior to co	empletion of cause of
al Real The The Triple of the	Ф	25. Was case referred to medical	26.Place of Death (Che	1 ✓ Yes 2 ck only one)	No 1 ✓ Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after cleath. al Director: After this certificate has been sited in by the funeral director, page 2 should be	P	1 163 2 140			esidence 6 Other:	
nding of the funer	ë	1 Natural 5 Rending (Month, Day, Year)	28c. Injury at Work? 1 Yes 2 X No	28d. Describe how		
Vision Atter des Directo	fical	2 Accident 3 Suicide 6 Could not be Suicide 2 Accident 6 Could not be Suicide 6 Could not be			eet and Number or Rur e)4305 South	al Route Number, City
Di ospital hours a peral I	Certification:	4 Homicide determined (Specify) Poo1		Hgwy. U	pper Marlb	oro,Md.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my	time, date and place, a opinion, death occurre	nd due to the cause(s	s) and manner as stated d place, and due to the	d. cause(s)
S S Mit S	Mec	and manner stated	License number		9d. Date signed (Moni	
			O.C.M.E.		July 31, 2011	
OCME		30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Bal	timore Street Pel	timore MD 2123	23	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		UE, NID 2122		
Regist		NIC 0 5 2011 1 1 1 1 1 1 1 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Frank M. Abrecht, Sr. 3:40 P M July 21, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Manor 5. Social Security Number If Under If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 Year 8. Date of Birth **Funeral** 1 ★ M 2 □ F Months Min Hours Feb. 6 Pay, Year 26 Mary Tand 219-20-2256 85 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location aţ rector ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland Frederick Frederick 悥 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21701 filed within 72 hours after death with 7996 Pleasant Court United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. "natural", Completed 3 X Widowed 4 Divorced WWII White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Fire & Rescue Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clyde Abrecht Wilmoth Adams Page 1 and 2 should be traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Frank Abrecht, Jr. / Son 7996 Pleasant Court, Frederick, MD 21701 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mt. Olivet Cemetery 1 X Burial 2 Cremation 3 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7/25/2011 Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 owth 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HRONC 0B5TRUZTELVE PULL-OLDRY DISSIAS YEAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical • Hospital or Attending Physician; The law requires that the death certificate be to a hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? cate has been signed by the atte page 2 should be detached for a Day 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No CORDUARY ARREST DISGHSE 24a. Was an autopsy performed 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar

5.41

To the P within 2 To the P

29a, Certifier

only one)

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOVEH

26

PO BON

32. Registrar's Signature

328

29b, Signature and title of certifier

RICHARD

31, Date filed (Month, Day, Year)

arks

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3217

29d Date signed (Month, Day, Year)

21793

22/11

29c. License number

WALKERSVILLE

11-03797 Edith Elizabeth B	oac	Please Type or Print in Black Indelib wine State of Maryland / Departmer	le Ink. Ensure All Copi of the All hand Mental I	i es Are Legibl e Ivaiene					
Editi Ellesson -			e of Death	Reg. No.	2011 2550				
Physicia	n/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 1445 hrs				
Medical Examir		Edith Elizabeth Boadwine 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	May 20, 2011	c. County of Death				
,		4a. Facility Name (if not institution, give street and number) 319 Blue Bay Road	Stevensville		Queen Anne's				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	ay) If Under 1 Year If Under 24H	rs. 8. Date of Birth(MM.	/DD/YYYY) 9. Birthplace (State or				
Director		508-82-2270 1 M 2 XF 54	Yrs. Months Days Hours M	July 1, 1	L956 Country Germany				
	ŀ	Usual Residence of Decedent			10d. Inside City Limits				
w any		10a. State 10b. County 10c. City, Town or			1 Yes 2 No				
r death with the Maryland or items 23a or 28a-f show must be notified at once.	ģ	Maryland Queen Anne's 10e. Street and Number	Stevensville 10f. Zip Code	T10g Cit	tizen of What Country?				
e Mary or 28a	Funeral Director								
ith the	ᇛ	64 Long Creek Drive 11. Marital Status 12. Was Decedent Ever in U.S. 1	21666 3. Was Decedent of Hispanic Origin? (ited States 14. Race - American Indian, Black,				
eath w	ne	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puer		White, etc.				
fter d	Ų.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: White				
ours 2		15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind or ring most of working life. DO NOT use re		Kind of Business/industry				
36 n 72 h	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Adm			Janu faatuurina				
Within Within	Completed	17. Father's Name (First, Middle, Last)	inistrative Assist	ne (First, Middle, Maider	Manufacturing Surname)				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		Oris D. Johnson	Sigrid	K. Wink					
21. ould b d Men s mar			Mailing Address (Street and Number o						
MD id 2 shc alth and m 27 is	ļ		O Bridgeview Lane, Disposition (Name of cemetery,		ille, Maryland 21666 Location - City or Town, State				
ore, salan of Hea	}		(or other place)	lav 22.					
Baltimore, permit. Pages I an Department of Hei Important: If ite		1 Denotion 5 Other Specific		2011 Ste	evensville, Maryland				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service Licensee Sue Burleson perDVR	22. Name and Address of Facility Fe Funeral Home P.A.	IIOWS, HeII	endein & Newnam				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest, sh	nock, or heart Approximate Interval Between Onset and				
Medical	- 9	failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning Complicated by Zol	oidem, Alprazolam and Alcoho	Intoxication	Death				
Examiner		or condition resulting in death) Due to (or as a consequence of):							
	_	Sequentially list conditions, if any, leading to inmediate Due to (or as a consequence or):							
	xaminer	cause. Enter Underlying Cause							
E G L	Xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
executed an and all - trans	edical E	d. UNPENDED AMENDED		·					
SO, te be c ysicia burial	ē	IF FEMALE: 23c. If yes, outcome of pregnancy		23	3d. Date of delivery				
Box 68760, e death certificate bb the attending physic cd for use as the bur	Physician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic preg		Month Day Year				
OX (sici	4 Pregnant at time of death 5 Unknown 9 Unknown 9 Unknown	Other (Specify)						
by the	Phy	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?				
P.O. es that the igned by be detach	ξ	Atherosclerotic Cardiovascular Disease		1 Yes 2	✓ No 3 Probably 4 Unknown				
rds, requir	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
e law e has	m			performed?	? death?				
ii Re	ပိ	25. Was case referred to medical	26.Place of Death (Che						
Division of Vital Records, P.O. Box 68760, talor Attending Physician: The law requires that the death certificate be executed as after death. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	.0 B	everniner?	patient 3 DOA Other Nur	sing Home 5 Resid	dence 6 🗸 Other: Scene				
I Of Ing Ph	-	27. Manner of Death 28a. Date of Injury 28b. Til	me of Injury 28c. Injury at Work?	28d. Describe how in Unknown	njury occurred				
	atio	2 Accident Investigation May 20, 2011 1445 I	nrs Tes 2 V No		Alimber of Burgl Books Number Ch				
Division or Attend safter death. Director:	Certification:	Suicide	n, street, factory, office building, etc.	or Town, State)	and Number or Rural Route Number, City d, Stevensville, MD				
Division of Voite to the Hospital or Attending Phyvithin 24 hours after death. To the Funeral Director: After to ompletely filled in by the funeral	<u>8</u>	4 Homicide 29a. Certifier 4 Certifier Physician To the heat of my knowledge death			·				
the H the F the F	edical	one) 2 Medical Examiner: On the basis of examination and/or inv	restigation, in my opinion, death occurre	d at the time, date and p	place, and due to the cause(s)				
2 ·5 ·2 ·5	ø	and planner stated.	20-1:	204	Date signed (Month Day Vear)				

5 OCME

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner State Registrar

DHMH 17 Rev 1/2001 OCME 2006

29b. Signature and title of certifie

32. Registrar's Signature

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25504 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year BUSH Μ. LAMONT 0 JUL 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death CENTER CITARL MEDICAL Social Security Number If Under 1 Year . Age (In vrs. last birthday If Under 24 Hrs. Sex 14 M 2 D F 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours DEC 26 1963 Months Min. FLORTDA Director 264-63-9410 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 1 X Yes 2 No CHARLES WALDORF 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a 9967 MORRISTOWN PLACE 20603 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc.
BLACK þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) IT SPECIALIST GOVERNMENT 4 YRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ should be CYNTHIA K. SELLERS SYLVESTER BUSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9967 MORRISTOWN PLACE WALDORF, MARYLAND 20603 nit. Page 1 and 2 sh artment of Health a ortant: If item 27 i VICTORIA BUSH/WIFE filmore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) RESURRECTION CEMETERY 7/29/11 CLINTON, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 910 Medical resulting in death) o (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🗀 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 X No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2X No autopsy Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2X No မ 1 Inpatient 2 x ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No the Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined To the Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifieng Nurse Proof Cortifieng Nur (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tamos T. Harring MD 102 Centennial St. Suite 102 LaPLATA, Md. 20646

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 3 Time of Death 2. Date of Death 22^{Day} 1. Decedent's Name (First, Middle, Last) Month 21:30P M **Physician** Frank Bolden 2011 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Months Days Hours 1 13℃M 2 1 F January 28,1944 Tennessee 67 Director 410-62-9853 Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State id other than "natural", or items 23a or 28a-f show event, the Medical Expr. from out to notified at 1 KrYes 2 □ No Upper Marlboro Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 United States 12602 Thrush Place by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: Black altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 3 ☐ Widowed 4 K Divorced 16b. Kind of Business/Industry
D.C. Department
of Human Services
Youth Services Admin. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. 12th Motor Vehicle Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H Be Jane Smith Frank Bolden မ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1604 Oak Street, Chattanooga, Tennessee 37404 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Betty Ann White/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Riverdale Park Crematory 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Riverdale, Maryland July 26,2011 Injury 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Pope Funteral Homes, P.A. 21. Signature of Funeral Service Licensee 5538 Marlboro Pike, Forestville, Md 20746 harles 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each interest. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and Due to (or as a consequence of) physician the burial Box 68760 the death certificate be Physician/Medical attending p as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Month 5 Other (specify) P.O. ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by The law requires that 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 20 No 1 ☐ Yes 2 ☐ No After this certificate 1 □Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 2 ER/Outpatient 3 DOA 1'⊞Inpatient ၉ funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner death 28c. Injury at Work? Certification: (Month, Day, Year) 1 atural 5 | Pending 1 ☐ Yes 2 ☐ No death. investigation s after death. 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University BLUD 831 EagL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lary Catherine E	Bra	gdon Sta 1- For State Registrar	te of Marylan		artment c <i>rtificate o</i>		and	Mental Hy		eg. No. 2	011	25506
Physicia Medical Examin		mary odenerine	e Bragdon						2. Date of Dea Month August 1,	Day 2011	Year	3. Time of Death 1018 hrs
		4a. Facility Name (if not institution, 7400 Guilford Drive	give street and numb	er)		4b. City, Tow Frederic		ocation of Death		4c. Cou Frede	nty of Deat erick	th
Funeral Director		212-17-8802	6. Sex 7.	Age (In yrs. I	last birthday) 29 Yr		Year Days	If Under 24Hrs. Hours Min.	-	rth(MM/DD/Y	Forei	rthplace (State or ign ountry) MD
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	15. Decedent's Education (Specific Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Line Derek Anthony	12. Was Deceding Armed Force 1 Yes ceed If Yes, Give Yeer or Dates: y only highest grade of College (1-4) ast) Bragdon	Fre	16a. Deceder during m	10f. Zip Co 21701 as Decedent c Yes, specify C Yes 2 X Int's Usual Occupation of working	of Hispa uban, M No cupation g life. D	n (Give kind of w O NOT use retire SOT Mother's Name	ecify Yes or No Rican, etc.) ork done ed) (First, Middle, I	Specion 16b. Kind o Medic Maiden Surna	tace - Amer white, etc. ify: Wh: f Business.	ite
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	10	19a. Informant's Name/Relationship Adam C. S. Krum 20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Spec 21 Squature of Funeral Service Lie	np — Husban 3 Removal from	State 20b.	544 I Place of Dispos crematory or of tropoli	Logan Sition (Name of their place) tan Cr	of ceme emai	nd Number or Ri Frederic tery, tory 08/ Facility Adve y Falls	Date O3/201 ent Fun	21701 20c. Locati Ale:	on-City or xandr Servic	Town, State
O, the execut sician and burial - tra	an/Medical Examiner	23a. Part MEnter the disease, or confailure. List only one cause or failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ned nsequence of nsequence of a , 27 , 2	f): f): 8a-f,pe		;919		1 sm		e of deliver	Approximate Interval Between Onset and Death y Day Year
P.O. es that the igned by be detached	Completed by Physician/M	1 Yes 2 No 9 ✔ Unknot	9 Unknown	at time of de	3 Ot	her (Specify) underlying cau	se give	en in Part I.	1 Yes	an 24 ssy	3 Prol	utopsy findings available completion of cause of
Division of Vital F ospital or Attending Physician: hours after death. neral Director: After this certifi y filled in by the funeral director,	Sertification: To Be	one) 2 Medical Exami	28a. Date of II (Month, Day gration 28e. Place of Section 28e. Pla	njury //Year) -11 Injury - At ho found: rking my knowledo kamination ar		3 DOA njury 28c. 1 8 am et, factory, officked ca red at the time	Ott Injury a Yes ce build Injury a Ar)	and place, and death occurred at	Home 5 28d Describe h unknown 28f Location (S or Town, S 27. Free due to the caus	Residence now injury occurs Street and Nu tate Walm ederic e(s) and man and place, and	mber or Ruart, 7k, Md.	r: Scene ural Route Number, City 400 Guilford ed. le cause(s)
R	2	29b. Signature and title of certifier Color Col	no completed cause of	•			C.M.	E	D 21223	August 2		nth, Day, Year)
Sta	ite	31. Date filed (Month, Day Year)	32. Regist	r's Sign au	Te A							

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

		-	For Amend#29d perMD - State Registrar	FCHD Cer	KS 8/2/11 tificate of De	eath	rentai mygi Re	ene 9. 2011_	25507		
	Physicia	n/	1. Decedent's Name (First, Middle, Last) James Francis Bouey				2. Date of Death July 22	1	3. Time of Death 11:50 a. M		
and a	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	July 22,	4c. County of Dea			
1			228 De Paul Street		Emmitsbu			Frederi			
	Funeral Director		5. Social Security Number 218-50-4783 6. Sex 1 → M 2 → F 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 16,	Year) 9. Birthplace (State or Foreign Country) 1951 Pennsylvania			
	ryland -f show ied at	ctor		Town or Loc					10d. Inside City Limits 1X Yes 2 □ No		
	h the Ma 3a or 28a be notif	Funeral Director	10e. Street and Number		10f. Zip Code 21727	7	1	0g. Citizen of What Co USA	ountry?		
	death wil r items 2: iner must	/ Funer	228 De Paul Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
9003	ours after tural", o	eted by	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🖼 No If Yes, Give Year or Dates.		Yes 2 X No			Specify.	white		
1215-	thin 72 hc ne. than "na ne Medic	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life, DC	kind of work done du D NOT use retired) Ouse supe1	ring most of worki	ng	16b. Kind of Business Retail sal			
ind 2	e filed wit tal Hygie ed other event, th	To Be C	17. Father's Name (First, Middle, Last) James Allen Bouey	waren		18. Mother's Name Mary Sa	e (First, Middle, M				
Baltimore, Maryland 21215-0036	should be h and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) Alba Bouey – wife	19b. Mailin 228 D	ng Address (Street an e Paul St	nd Number or Rura	il Route Number.	City or Town, State, Z , Maryland	ip Code) 21727		
lore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ace of Dispos emetery, crem	sition (Name of natory or other place,	! .	Date	20c. Location - City o	r Town, State		
3altin	ermit. Pa epartmer nportant ny injury nce.		21. Signature of Funeral Service Licensee	22	Crematory . Name and Address	of Facility St	auffer F	uneral Hom	ie		
	70 F # 0	7	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					erick, Mar	Approximate Interval Between		
1	nysician/ Medical	ľ	Immediate Cause (Final disease or condition resulting in death) a. Due to (or 5: a conneque	RDIV	al is	chemi	n		Onset and Death		
	Examiner	ier	Esquentially list conditions, if any, leading to immediate Metasta Due to (or as a consequence)	tici	ung C	meer			Months		
	and transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):								
200	icate be executed I physician and s the buríal-transit	dical	d								
Box 687	th certif ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown IF FEMALE: 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	23d. Date of d Month	elivery Day Year						
s, P.O.	ires that the dea signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resu	ılting in the u	ınderlying cause give	en in Part I.			to the cause of death? Probably 4 Junknown		
Division of Vital Records, P.O.	The law require ate has been si page 2 should I	Completed					24a. Was ai autops perforr 1 \(\sum \) Yes	y prior to ned? death?	utopsy findings available completion of cause of es 2 No		
tal	ician: sertifica ector, I	Be	25. Was case referred to medical examiner?		26. Plac	ce of Death (Chec					
of V	ing Phys After this o	ate: To	1 ☐ Nes 2 ☑ No 1 ☐ Inpatient 2 ☐ E 27. Manner of Death 28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	nt 3 L DOA 28c. Injury work?	4 □ Nursing Ho at		ence 6 Other (Spe w injury occurred	ocify)		
ivisior	or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2 v	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)			Yes 2 □ No	28f. Location (St. City or Town	reet and Number or Rural Route Number, , State)			
Ω	To the Hospital or within 24 hours aft to the Funeral Dir completed filled in	Medical	29a. Certifier (Certifying Physician: To the best of my knowle (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	and/or invest	tigation, in my opinior	n. death occurred a	t the time, date an	d place, and due to the	e cause(s) and manner stated.		
	To the within To the comple	Σ	only one) 3 \(\subseteq Certifying Nurse Practioner: to the best of my 29b. Signature and title of certifier	V.	29c. License			9d. Date signed (Mor	oth, Day, Year 07/25/1		
	12		30. Name and address of person who completed cause of death (Item	23a) (Type, F	exint)	derek	MD 2	1702			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu		had 1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Caro1 Buckler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata narle La 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Min 1 □ M 2 🗶 F Months Hours 70 1941 Washington. D.C Director 577-58-2229 13. Usual Residence of Decedent 10d Inside City Limits 28a-f show 10b. County 10a. State 10c. City, Town or Location death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No St. Mary's Mechanicsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ò Funeral items 23a 38463 Sonny Lane 20659 S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 X Married filed within 72 hours after White and 21215-0036 1 ☐ Yes 2 X No Specify. Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Transportation Bus Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or care မ Hilda E. Hines Joseph A. Sullivan Marýk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Box 38, Mechanicsville, MD 20659 James Leroy Buckler/Husband P.O. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 08/06/2011 Mechanicsville, MD 4 ☐ Donation 5 ☐ Other (Specify) All Faith Church Cem. 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Fu 30195 Three Notch Rd., Charlotte Hall, MD 20622 an **№**00174 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due t (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the 9 V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying gase given in Part 3e. Did topacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) l B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man er of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniurv 5 \square Pending 10 Natural Investigation ☐ Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Centifying hysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Mr. included a miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Co. lifting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 29b. Signature and title of 29c. License number 30. Name and ad was of per on who completed cause of death (Item 23a) (Type, Print) M.D. OL

State Registrar

rkler

Date filed (Month)

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Ma	-	partment of H ertificate of D			ene 2.011	25509	
i	Physicia	n/	Decedent's Name (First, Middle, Last) Donald Edward Bryant				2. Date of Death		3. Time of Death 6:30 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		***	Location of Death	nagase	4c. County of Death	h	
	Funeral		39563 Jarrell Drive 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign	
	Director		577-52-5741	75 Yrs.	Months Days	Hours Min.	Nov. 16	1935 Cal	ifornia	
	/land f show ed at	tor	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits	
	ne Man or 28a- notifie	Funeral Director	Maryland St. Mary's 10e. Street and Number	Mechai	nicsville 10f. Zip Code		11	0g. Citizen of What Co	1 Yes 2 X No	
	with the same same same same same same same sam	eral	39563 Jarrell Drive		206	59		United St		
036	s after death ral", or items Examiner m	þ	11. Marital Status 1 □ Never Married 2 🗶 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 ₺ Yes 2 □ If Yes, Give Year or Dates.		3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	rican Indian, e, etc.	
21215-0036	ithin 72 hour ene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5)	(Gi i+)	cedent's Usual Occupa ve kind of work done o . DO NOT use retired) efighter		ing	16b. Kind of Business Fire Depa		
þ	e filed w ntal Hygi ed other event, t	To Be	17. Father's Name (First, Middle, Last) George Bryant	1 1 11	erighter	18. Mother's Nam	·	aiden Surname)		
Maryland	hould b and Mer s mark umatic		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street a	Mary M and Number or Rura		City or Town, State, Zip	Code)	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		Jeanette Bryant/Wife 20a. Method of Disposition		563 Jarre1	Lurive,		sville, MD		
mor			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, c	rematory or other place eld-Echols		2011	•	te Hall, MD	
Baltimore,	permit. Departn Importa any inju		21. Signatury of Funeral Septics Licensee	M00817			nsfield-	Echols F.H lotte Hall	., P.A.,	
	hysician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	the death. Do not e.	enter the move of dyline	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Cnset and Death	
	Medical Examiner		resulting in death) a. Due to (or as	a consequence of):	hetmit	ivi Pw	MINIM	1 DILLAGO		
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a consequence of):	Nama 1	UNA		/ 3		
	e execute cian and urial-tran	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of the con							
3760	ficate b g physia ss the b	l edical	d	MANO	M dQ - M -	VIII				
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of de Month	llivery Day Year	
ds, P.O.	quires that the dea en signed by the a ould be detached f	þ	Part II. Other significant conditions contributing to death be a significant conditions contributing to death be a significant conditions contributing to death be a significant conditions.	out not resulting in the	ne upderlying cause giv	ren in Part I.	23e. Did tob	oacco use contribute to	the cause of death?	
Division of Vital Records,	sician: The law require certificate has been s rector, page 2 should	Completed			`		24a. Was ar autops perforr 1 🗆 Yes 2	by prior to death?	topsy findings available completion of cause of	
/ital	sician; certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Hospital:	ent 2 🗆 ER/Outpa	Othe	ace of Death (Chec		ence 6 Other (Spec	264	
on of \	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	icate: T	27. Manner of Death 1	ry 28b. Time	e of 28c. Injury	/ at		w injury occurred		
Division	al or Atte s after de I Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuding, etc.	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or A within 24 hours after To the Funeral Direc completed filled in by	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	examination and/or in	vestigation, in my opinio	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.	
	To the To the Column to the Co		29b. Signature and title of certifier		29c. License	23826	2	9d. Date signed (Mont 3 -4-]]	h, Day, Year)	
Bu	vl.		30. Name and address of selson who completed cause of Colonia (Colonia)	leath (Item 23a) (Typ	Old By	mch Aw	Clim	to mi	20735	
	Sta Registra		31. Date filed (Month, Day Vear) 32. (egistr.	ar's Signature	back	W. IL.	S OVII)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Barbely Nancy Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) or Location of Death **Examiner** a Sa USPUN Willowi If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🏝 F Months Hours Min. 06/23/1944 Maryland 219-42-8496 Director 67 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Volusia Port Orange lorida 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 32128 Funeral USA 2733 Spruce Creek Blvd Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Black, White, etc. Completed by Yes 2 X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0d36 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marquerite Shores Edward Franklin Brewington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code 2733 Spruce Creek Blvd, Port Orange, FL 32128 19a. Informant's Name/Relationship (Type, Print) Wayne Barbely/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Shad Point Cemetery 1 K Burial 2 Cremation 3 Removal from State 7/25/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signature of Fungal Sérvice Lig 22HollowayssPimeral Home Professional Association 501 Snow Hill Rd. Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARCINDUMA MAHGNANT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2/ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: HOSPICE ER/Outpatient 3 DOA 4 Nursing Home 5 Residence ပ 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1/2 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0058410 OTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar gistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25511 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15:58 PM 67 Medical 26 i 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Days Hours Min 05/15/1924 145-18-4713 87 **Director** Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Somerset Marion Station 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1 Funeral 5169 Cornstack Road 21838 U.S.A should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grower Poultry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milton O. Briddell Evelyn Powell .. Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Milton Briddell (Son) 5169 Cornstack Road-Marion Station, MD 21838 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If in any injury or o 1 X Burial 2 Cremation 3 Removal from State Rehobeth Baptist Cem. 4 Donation 5 Other (Specify) 07/26/2011 Rehobeth, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Cristield, Signature (File 19 Sould) House Robert H. Bradshaw. 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ntraventric Medical Due to (or as a consequence of) Examiner neumon. Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 9 Unknown g Unknown P.O. I signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 \square Yes 2 \square No 3 \square Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d Describe how injury occurred 28c. Injury at iniury work? 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature an 29d. Date signed (Month, Day, Year) DEA: AU 1476435 B100552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

NUN

32. Registrar's Signature

Suite S-12D Baltimore

11-05500 Robert L. Barks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert L. Barks	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Certificate of Death	25512
Physician/ edical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year July 23, 2011	Time of Death 1454 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cecil Cecil	12
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 x M 2 F 59 Yrs. 7. Age (In yrs. last birthday) 1 x M 2 F 7. Age (In yrs. last birthday) 1 x M 2 F 59 Yrs. 7. Age (In yrs. last birthday) 1 x M 2 F 59 Yrs. 1 x Months 1 x M 1 x Min. 1 x	
ith the Maryland 23a or 28a-f show any notified at once. al Director	MD Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 10 West Race Street 21901 USA	
or items must be	3 Wildowed 4 Divorced in test, sive tear 1 Yes 2 X No specify: W	Vhite
21215-0036 out be filed within 72 hour I Mental Hygiene, in arrived other than "natu ic event, the Medical Exan To Be Completed	Robert Woodrow Barks Catherine Louise Harlow	e
F 정불 등 등	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z Kathleen Shifflett	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: Forest Cemetery 08/02/2011 MIddletown 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home 259 East Main Street, Elkton, MD 2192	e, P.A.
Physician Madical Examiner	7 000	Approximate Interval Between Onset and Death
ed nsit Examiner	Sequentially list conditions, b.	
0, be execut sician and vurial - tra	x UNPENDED	
(ecords, P.O. Box 68760) The law requires that the death certificate be execut ate has been signed by the attending physician and age 2 should be detached for use as the burial - tranompleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 9 Unknown	
is, P.O. quires that the en signed by a lid be detache	1 Yes 2 No 3 Probab	5-3
Zec The I		npletion of cause of
Vital I hysician: this certifit all director,	examiner? Hospital: 4 Lacations 2 ED/Outpetiest 2 DOA Other, Nursing Home E Registeres 6 Others	cene
ion of vending Phesath. tor: After the funeral attion: To	27 Manager of Dorth	
Division or Attending. To the Bospital or Attending, within 24 hours after the To the Funcral Director: After completely filled in by the fune Medical Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural or Town, State)	Route Number, City
To the Ho within 24 Pro the Fu completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To with To com	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month) July 24, 2011	, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra	31. Date filed (Month Pro Year) 32. egistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** aVerne 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State o. If Under 1 Year | If Under 2 6. Sex Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2**X**F Hours Months Days Min. 85 Pennsylvania 8876 3-21-1926 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Llagerstown 70f. Zip Code MD Washington 10g. Citizen of What Country? 10e. Street and Number 740 U.S. 12. Was Decedent Ever in U.S Armed Forces? Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than 'any lipury or other traumatic event, the Meones. Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) BATHE Nors 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NePhen Angle PA 17268 Landis 20a. Method of Disposition Waynesboro 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8/5/2011 Cornelius Chumbersburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.L. 21. Signature of Funeral Service Licensee M01414 Nis Bradbury Ave. 12525 21785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 weeks Theno much /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 ☐ Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed certificate 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 36 Hagestern 21740 HA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

11-05503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

King Curtis	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20 1 255 4
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year July 23, 2011 3. Time of Death 1853 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death PRMC 4c. County of Death Wicomico
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. May 24, 1459 Country) Maryland
Maryland 28a-f ahow any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nevyland Somerset Princess Anne 1 X yes 2 No
the Mary is nr 28s-riffed at	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.
er death with the Maryland , or items 23a nr 28a-f sh r must be notified at onco Funeral Director	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked uther than "natural", or items 23a nr 28s-f sho ir other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	or Dates:
ID 21215-0036 should be filed within 72 hourn and Mental Hygiene. 7 is marked ather than "natu natic event, the Medical Exan To Be Completed	17. Father's Name (First, Middle, Last) King Edward Curtis St. 18. Mother's Name (First, Middle, Maiden Surname) Novella Jones
MD 21. 3.2 should Eth and Mer 3.7 is mar numatic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell P. Curtis Sr Brother 31048 Eden Allen RJ., Eden, Md., 21822
	20a. Method of Disposition 1
	22. Name and Address of Facility Anthony E Word F. H. 30039 Hempden Av, F. n.c. 55 Anne, mp. 31853 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease complicated by Hyperthermia Between Onset and Death
	Sequentially list conditions, b
ted insit Examiner	cause. Chief Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
execution and the state of the	d. UNPENDED AMENDED
ox 6876 ath certifical attending ph or use as the	
ires that the de signed by the detached f	1 Yes 2 No 3 Probably 4 🗸 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that thread reach. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
fital Residua: The is certificate lirector, page	25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital:
Division of Vi To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director dedical Certification: To	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
Division o wpital or Attending hours after death. neral Director: Aft / filled in by the fune Certification:	3 Suicide 6 Could not be determined Coperation (Specify) Yard 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Yard 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11230 Greenwood School, Princess Anne, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	
	Januela Trouthall, MI) O.C.M.E. July 24, 2011
46	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registra	
DHMH 17 Rev 1/2001	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month C7 - 24- 2011 2:32 AM Wilson Dunn 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Wicomica Hospice Lake Salisbury If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Hours 7-28-1925 85 Tennessee 414-22-2061 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Mt. Hermon Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No 1941-1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 1947 White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welding Supply Co. 10 Purchasing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dunn Jessie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Dunn - Wife 1800 Mt. Hermon Road, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Springhill Memory Gds 7-29-2011 Hebron, Maryland 21. Signature of Fune al Service License

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

ral", or items 23a or 28a-f s Examiner must be notified

"natural"

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I

Page 1 and 2 should be

with the Maryland

Maryland 21215-0036

Baltimore,

attending physician

Division of Vital Records, P.O. Box 68760

	resulting in death)	a								
		Due to (or as a consequence of):								
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):								
lical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a consequence of):								
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
y P	Part II. Other significant conditions of	ontributing to death but not resulting In the underlying cause given in Part I.	23e. Did tobacco i							
q pa			1 □ Yes 2							
Complet			24a. Was an autopsy performed?							
Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)							
2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6							
ficate:	27. Manner of Death Matural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur							
I Certi	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street an City or Town, State							
Medical Certificate:	(Check 2 Medical Exami	sician: To the best of my knowledge, death occured at the time, date and place, a iner: On the basis of examination and/or investigation, in my opinion, death occurred a se Practioner: To the best of my knowledge, death occurred at the time, date and pla	at the time, date and place							

22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. P. 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cruze on each line.

Immediate Cause (Final disease or condition Condition Condition) Onset and Death 23d. Date of delivery Month Day Year use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Fother (Specify) Hospice at ialis v occurred d Number or Rural Route Number, nd manner as stated. and due to the cause(s) and manner stated and manner as stated 29c. License number 29d. Date signed (Month. Day, Year) D63199 231111 71 SALISBURY, MD, 2 1804 BR.

Registrar DHMH 17 Rev 7/2009

State

the Hospital or Attending Physician: ' hin 24 hours after death, the Funeral Director: After this certific

filled in by

29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#23a(b)perPHY FCHD KS 7/29/11

Certificate of Death

Reg. Ng for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{2} 0 \underline{1} \underline{1}$ Rachel Lee Emrich July Physician/ 3:55 A. M 22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Thurmont 18 Meadow Lane Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🔀 F 99 Months Hours (Month, Day, Missouri 219-10-4200 **Director** Dec Usual Residence of Decedent 28a-f show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location Thurmont 10d Inside City Limits Director Maryland Frederick 1xxYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 USA 18 Meadow Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot မ Martha Jones Department of Health and Ment;
Important: If item 27 is marriany injury or car. Charles Franklin Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8338 Myersville Road, Middletown, Maryland Trexler - Daughter Margo Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Frederick, Maryland 7-30-2011 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 21. Signalus of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death h sician/ disease or condition MAXIE Medical resulting in death) Due to (or as a conse lugi Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a cons Examir The law requires that the death certificate be executed diseco and Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending ph d for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death ate has been signed by the page 2 should be detached Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ failure Records, Heavt 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed this certificate 2 No Yes 1 🗌 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျာ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier A Humai

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSSAIN

32. Registrar's Signature

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FREDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>01</u> Month Physician/ 110C Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arundel nhapo (on to Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Hours 1 M 2 KF ary Yrs 190 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 No Hunde 10g. Citizen of What Country? 10e. Street and Number Funeral rivia 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married 1 Yes If Yes, Give 2 1 ☐ Yes 2 Ho Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. It is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) NA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 tran K 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. George Frank 184 Springhouse La Baltimore, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory 20a. Method of Disposition 1 Burial 2XCremation 3 Removal from State 17/27/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 our 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pagulopa disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months? Month Day Pregnant at time of death Yes 2 No To the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24a. Was an autopsy performed? Yes 2 the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director: After this certificate has be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 Tes 2 No 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 7 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

State Registrar 31. Date filed (Month, Day, Year)

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Arlene Golden Linda Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death -Regional Medical Cumberland Allegany Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth 1 □ M 2 □ F Months Hours Min. Aug 24 **Director** 214-48-2947 Usual Residence of Decedent 28a-f sho 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a 1013 Frederick Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highe est grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Attornev Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Harvey R. Golden Gracine Schade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Gracine Golden mother 1013 Frederick Street Cumberland MĎ 21502 Health tem 27 item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Brurial 2 Cremation 3 Removal from State Hillcrest Memorial Park 8/4/2011 MD 4 ☐ Donation 5 ☐ Other (Specify) Cumberland 22. Name and Address of Facility Paris Home, PA 21/Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I. Enter the disuas, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 115/17 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of: the burial-tran Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Hospital or Attending Physician. The law requires that the death certificate be each hours after death.

I hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death detached been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dealt 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Tyes 2 🗌 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 250

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0300 M EGINA Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MI Olney Montgomery neral Montzone Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1960 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗶 F Days Hours 577-92-2188 51 Washington, D.C. January Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland | Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 14100 Parkland Drive 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) District of Columbia Elementary/Seconday (0-12) College (1-4 or 5+) Physical Education Teacher 6 years Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lucille Parrish Robert Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pierre Michele Hawkins (Husband) 14100 Parkland Drive; Rockville, Maryland 20853 20b. Place of Disposition (Name of contractory, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth Aug.6,2011 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cemetery Silver Spring, Maryland Gáte 21. Signature of uneral Service Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ respirator disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ φ Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autoosy page 2 performed death? 2 No Yes **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death 1 Natural 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 5 Pending injury Accident Investigation filled in by the Suicide 6 Could not be 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 25,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHINTH SHARMA MD Montgome 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:00AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Kent Ster ver Manor Nursing If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 M 2 D (Month, Day, Months Days Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 A 6 Was Decedent Ever in U.S Armed Forces? 1 P Yes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 3altimore, Maryland 21215-0036 <u>م</u> 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced Jack Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COMPan Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke, any injury or other traumatic e Cer injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nthone 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) aron() hapel Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of cility Home, eral Str 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acciden Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Unidentify Cause (Disease or iinjury Exam requires that the death certificate be executed and -tran: that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No s been signed by the should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has by page 2 s autopsy perform certificate 1 Yes 2 XNo 1 Yes 2 XV 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, ျပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending injury **Natural** death. 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director; of the formula in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: 1 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 only one 29b. Signatur nd title of 00060301 Sometimes of death (Item 23a) Type, Print) 5785

Registrar

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1732 JUL 2011 /Medical 4c. County of Death 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death Examiner AMDRIDGE Dorchester HOSPITAL GENERAL **brchester** 9. Birthplace (State or Foreign Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days 1 ☐ M 2 🛛 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Evandor a ust be natified at 1 □Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 Never Married 2 Married 1 □Yes 2 X No Specify þ 3 Nidowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours popartment of the health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa-Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State Cambridge 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licensee 2/10/3 Part Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIA hr /Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-tran be exec Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been signs ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown INSU HOC Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 53253 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston Sniezek Choptank MD J 3683 Timoth MD 32, Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August 11:56 PM 201 Benjamin Andrew Havenner, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 □**X**M 2 □ F Months Min. Days Hours Washington, DC **Director** 218-20-0404 84 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Funeral "natural", or items 23a 6211 Rosecroft Drive 20744 United States should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Dorsey Benjamin A. Havenner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 st trrent of Health a tant: If item 27 is jury or other tra 6211 Rosecroft Drive, Fort Washington, MD 20744 Dorothy Havenner/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 9,2011 Cheltenham, Maryland Maryland Veterans Cem 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., Sunat e of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Cardiapulmonary

Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sypsis Days Jundsom Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of Examine URINAY Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Completed Impaired Renal Function 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Depletion performed ? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature, and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 2011

State Registrar 30. Name and address of person who com

ted cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physician/ Medical Examiner Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death 3. Decedent's Name (First, Middle, Last) 3. Decedent's Name (First, Middle, Last) 3. Decedent's Name (First, Middle, Last) 4. Decedent's Name (First, Middle, Last) 3. Decedent's Name (First, Middle, Last) 4. Decedent's Name	Reg. N2 0 1 25523 ath Day 1 3. Time of Death S:42 A M 4c. County of Death Wicomico th Year 1925 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry refinery Maiden Surname) Interpretable A Surname Maiden Surname
2. Date of De Month July 2	3. Time of Death 3. 2011 4c. County of Death Wicomico 4c. Year) 9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry refinery Maiden Surname) Impson Maiden Surname) Impson Maiden Surname, Maiden Surname, Springs, MD 21837
Physician/ Medical Examiner John S. Hinkle 4a. Facility Name (if not institution, give street and number) 9830 Sharptown Road Funeral Director 5. Social Security Number 151-14-2042 1 M 2 F	4c. County of Death Wicomico 19. Birthplace (State or Foreign Country) 1925 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry refinery Maiden Surname) Impson Maiden Surname) Springs, MD 21837
Funeral Director 4a. Facility Name (if not institution, give street and number) 9830 Sharptown Road 5. Social Security Number 151-14-2042 4b. City, Town, or Location of Death Mardela Springs 6. Sex 1	4c. County of Death Wicomico th Wicomico 9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry refinery Maiden Surname) Impson r, City or Town, State, Zip Code) Springs, MD 21837
Funeral Director 5. Social Security Number 6. Sex 1 1 1 1 N 2 F 7. Age (In yrs. last birthday) 86 Yrs.	9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Pes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry refinery Maiden Surname) Impson M. City or Town, State, Zip Code) Springs, MD 21837
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The state of the s	Maiden Surname) pmpson r, City or Town, State, Zip Code) Springs, MD 21837
To Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) John S. Hinkle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	Maiden Surname) pmpson r, City or Town, State, Zip Code) Springs, MD 21837
John S. Hinkle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	r, City or Town, State, Zip Code) Springs, MD 21837
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No. Irene Hinkle (wife) 9830 Sharptown Road Mardela	-1 0,
20a. Method of Disposition 20b. Place of Disposition (Name of Date	200. Location Oity of Town, Otato
1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Crematory of Delmarva 07-26-2011	Delmar, Delaware
21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Short Funeral Home	
That Divite 13 East Grove Street De	lmar, DE 19940
23a. Part 1. Enterighte disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Immediate Cause (Final	rest, Approximate Interval Between Onset and Death
Physician/ Medical Immediate Cause (Final disease or condition resulting in death) Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b.	
if any, leading to immediate Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last C. Due to (or as a consequence of):	
d e burial	
d. FFEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part Other stratificant and little to death but and earlies in the underlying square in the part 2 Characteristic and earlies in the underlying square in the underlying squ	
23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown 9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	obacco use contribute to the cause of death?
adulite (
The law required. 24a. Was autopered. 1	
1 Ves 25. Was case referred to medical 26. Place of Death (Check only one)	2 No 1 Yes 2 No
25. Was case referred to medical examiner? 1	dence 6 Other (Specify)
27. Manner of Death 28a. Date of injury 28b. Time of injury at work?	ow injury occurred
28a. Date of injury 28b. Time of injury at work? 1	Nevert and Number or Duml Payto Alumbar
A b s a b a b a b a b a b a b a b a b a b	Street and Number or Rural Route Number, In, State)
Part	nd place, and due to the cause(s) and manner stated.
29b Signature and title of settiffer	29d. Date signed (Month, Day, Year)
20 Name and address of parent who appropriated across of data (them 23c) (The Data)	7-25-11 USBURY, UND 21802
30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) AVIO COWALL, MID COASTAL HOSPIKE PO BOX 1733 SAC	15BURY, MM 21802
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ John Francis Hickman 2145 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Paninsula Regional Medical Cente alisburt WICOMICO If Under 24 Hrs. If Under 1 Year 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 D F Months Days 01/12/1921 Maryland 220-09-1899 Director 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director notified 1 ☐ Yes 2 🛣 No 28a-f Maryland Wicomico Salisburv 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? pe must be Funeral 1007 Grant Ave. permit. Page 1 and 2 should be filed within 72 hours after death with 21804 USA items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Examiner. Black, White, etc. 0 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White 3 Widowed 4 Divorced Specify: "natural", Navy Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Agent Insurance and Mental Hygiel Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Henry Preston Hickman Margie Disharoon 19a. Informant's Name/Relationship (Type, Print)
Frances Hickman/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Grant Ave., Salisbury, MD 21804 Health and tem 27 is n Important: If item 27 any injury or other the once, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial 7/25/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Pregnant at time of death 5 Other (specify) signed by the and be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Watural 5 Pending work?
1 Yes 2 No 24 hours after death Funeral Director: A Accident Investigation the 1 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date death (Item 23a) (Type, Print) Date filed (!) State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 23b per doc 9918 8-10-11 vt State of Maryland / Department of Health and Mental Hygiene 25525 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year GERTRUDE HUEBNER 2014 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death umma TIMERE 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🛛 F 09/20/1919 Country) **Director** 211-12-6156 91 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2 X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Bollinger Road 21157 USA items i "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nelson Parker Cribbs item 27 is marke other traumatic Emma Mae Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul M. Huebner, Sr./husband 1221 Bollinger Road, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o õ tX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem. 08/01/2011 Westminster, MD Signature of Funeral Service Lice 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CESPICATORdisease or condition resulting in death) Medical Due to (or a a consequence o Examiner Myocardial Infarction Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Dav Vear g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🕦 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has a completed filled in by the funeral director, page 2 s performed 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) RES 000 7.28. 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print) GEVENE ST BALTIMORE, MD 2120 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Todd Hart		State of Maryland / Department of Health and Mental h	Hygiene	Reg. N	201		25526
Physicia Iedical Examin	n/	1. Decedent's Name (First, Middle,Last) James Todd Hart	2. Date of Domestin Month July 31,	Day 2011			3. Time of Death 1220 hrs
Funeral		4a. Facility Name (if not institution, give street and number) Bridgetown Road 4b. City, Town, or Location of Dea Greensboro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H				9. Birth	place (State or
Director		219-68-9790 1 M 2 F 54 Yrs. Usual Residence of Decedent	June	4,	1957 F		"Maryland
th the Maryland 23a or 28a-f show any notified at once.	al Director	10a. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 282 Pinoak Drive 21701 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sacrif. Van	Un	Citizen of What	Counti	•
s afte	ted by Funeral	Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puer	of work done		White, e	whi	te
21215-0036 Uld be filed within 72 Mental Hygiene marked other than " cevent, the Medical.	Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bricklayer 17. Father's Name (First, Middle, Last) 18. Mother's Name		e, Maio			
ore, MD 21215-00; as 1 and 2 should be filed with of Health and Mental Hygiene If item 27 is marked other If her traumatic event, the Mee	To Be	19a Informant's Name/Relationship (Type, Print) Lauren Hart (Daughter) 19b Mailing Address (Street and Number of 15 Peach Orchard Ct.)		lumber, SW i C	nber, City or Town, State, Zip Code)		
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory 8/		LS		urg	, Maryland
Balt Bernit. Depart Import		21 Signature of Funeral Service Licensee MO1612 22 Name and Address of Famility Keeney & Basford 106 E. Church St. 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line Multiple Injuries complicating Address of Famility Keeney & Basford 106 E. Church St.	P.A. Fu Frede	iner eric	al Home k, Mary shock, or heart	e ylar 	nd 21701 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiovascular Disease Due to (or as a consequence of):	unerosc.	rerc	otic		Death
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): d.					
'60, cate be exect physician an	Medical	✓ UNPENDED AMENDED 23a,pt.II,27,28a-f,per me,g918 IF FEMALE: 23c. If yes, outcome of pregnancy	8-11-1		m 23d. Date of de	elivery	
Box 6876(e death certificate the attending phy ed for use as the b	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)			Month	Da	
fs, P.O. quires that the en signed by uld be detach	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Phencyclidine and cocaine use		Yes 2	No 3	Proba	ne cause of death? ably 4 Unknown opsy findings available
of Vital Records, ng Physician: The law require then this certificate has been sineral director, page 2 should be	Completed	25. Was case referred to medical 26 Place of Death (Chec	_ au pe 1 ✔ Ye	topsy rformed	prid d? dea		empletion of cause of
of Vita ing Physician After this cer iuneral direct	: To Be	evaminer?	sing Home 5		injury occurred	CIL	Ject was
ivision or Attendir after death. Director: A	ertification:	Natural Nat	28f. Locatio	n (Stree n, State	et and Number) Bridge	or Rura	cle that or vehicle al Route Number, City n Rd
To the Hospital within 24 hours To the Funeral completely filled	Medical Co	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated	and due to the c	ause(s)	and manner a		
F » F »	Me	29b. Signature and title of certifier O.C.M.E.		١.	ed. Date signed		th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223				
Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Signature					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		for State RegistrarFCHD peri		-		artment of l htticate of l		ivientai my	Reg. N	0 1 1	255	127
Physicia	n/	1. Decedent's Name (First, Middle						2. Date of De	eath Day	/ Yea	3. Time o	
Medic Examin	al	4a. Facility Name (if not institution					r Location of Death	JULY	22,20	011 County of De	eath 9:0)7A M
Funeral	-	FREDERICK MEMO 5. Social Security Number 454-36-4347		Age (In yrs. la		FREDEF If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	irth Ey, Year)	FREDEI	SITUN Birthplace (State Country) XAS	or Foreign
Director		Usual Residence of Decedent		8	2 Yrs.			pet. Z.	5, 19	20 16	xas	
Maryland 28a-f sho otified at	Funeral Director	10a. State 10b. County Maryland Frede			y, Town or Lo						10d. Inside 0	City Limits
vith the	ralD	10e. Street and Number 5731 Magnolia T	ree Court	Apt. A	43	10f. Zip Code 2170	3		_	izen of What		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Mari	12. Was Deceder Armed Force 1 Yes 2	ent Ever in U.Ses?	3. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, Wl	merican Indian, nite, etc.	
nours a	eted	3 X Widowed 4 Divorced	Year or Date nt's Education	s. Kore	an	dent's Usual Occur			 _	Specify: I	Black	
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d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, L Albert Jackson	ast)				18. Mother's Nar Mary Le			Surname)		
12 shoul lith and I 27 is m r trauma		19a. Informant's Name/Relationsl Laurie Aldridge Laurie Aldright	nip <i>(Typ</i> e, <i>Print)</i> • / Daughte	r		ng Address <i>(Str</i> eet Magnolia						3
Page 1 and lent of Hez int: If item iny or othe		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from St	20b. F	lace of Dispo emetery, crer	psition (Name of matory or other place)	ce)	Date	20c. Lo	ocation - City	or Town, State Texas	
permit. F Departm Importa any inju		21. Signature of Funeral Service L		Joeu	R ² C	Name and Addre	SS of Facility &	SON FU	NERAL	HOMES	, P.A.	
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	emplications that cau	used the deat						CK, ML	Approxima Interval Be	etween
Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or	as a consequ	uence of):	Bowel	1 1.				Onset and DAY YEAR	>
LAGIIIIICI	ner	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequ	uence of):		.lar di	Sease				
xecuted n and al-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	U	as a consequ		0515					YEAR	·>.
cate be e physicial the buri	edical	¥	L _{d.}									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Feta nt at time of c	al death 3	Ectopic pregnand Other (specify)	су			23d. Date of Month	delivery Day	Year
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w requires been second	pletec		-11 (00)					24a. Was	s an	24b. Were	autopsy findings to completion of	s available
The la icate ha r, page 2		25 W						perl 1 🗆 Yes	opsy formed? 2 No	death		
lysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2 🗆	ER/Outpatie	26. P	lace of Death (Che er: 4 \sum Nursing F	<i>ck only one)</i> łome 5 ☐ Res	idence 6	Other (Sp	ecify)	
anding Ph aath. or: After th he funeral	Certificate:	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investig	28a. Date of (Month, gation		28b. Time of injury	28c. Injur work	y at	28d. Describe				
tal or Atterns all Directo		3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of	Injury - At ho , etc. <i>(Specify</i>		eet, factory, office			(Street and wn, State)		Rural Route Num	nber,
e Hospi n 24 hou e Funer	Medical	(Check 2 L Medical E	Physician: To the bes examiner: On the basis Nurse Practioner: To	of examination	n and/or inves	tigation, in my opini	on, death occurred	at the time, date	and place,	, and due to th	ne cause(s) and m	nanner stated
To the vithin comp	2	29b. Signature and title of certifier		>		29c. Licens	e number		29d. Dat	te signed (Mo	nth, Day, Year)	GII
3+1		30. Name and address of person		of death (Item	23a) (Type, I	Print) 7th	Stre	+ Fu	red	eric	k	-
Stat Registra		Tauzi Kizu 31. Date filed (Month, Day, Year) JUL 2	32. Reg	istrar's Signat	ture	barke	J. 10	<u>_, , , , , , , , , , , , , , , , , , , </u>		-,,		
ricgistia	•	JUL &	- FALL	S CONTRACT	10. 14	F 50 07						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2011 Day 23 AM Ethyline Johnson July 7:54 Medical 4a. Facility Name (if not institution, give street and number)
520 Glenburn **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Nursing Center Dorchester Avenue Cambridge 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday, 1 🗆 M 2 🔀 F Months Director 226-28-2400 Virginia November Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Cambridge Maryland Dorchester death with the 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 904 Washington Street 21613 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 'natural", or 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 K Widowed 4 Divorced Completed Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Food Processor Cannery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grant. Chandler . Eaves Amy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau Mary C. H. Roy / Neice 56 Confederate Way Stafford, Virginia 22554 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetary July 30, 2011 Cambridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 812 Hubbard Street Boardley Funeral Home Cambridge, Maryland 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? for Month Pregnant at time of death Day Year the should be detached 9 🗌 Unknown 9 Unknow P.O. signed by 23e. Did tobacco use contribute to the cause of death? þ 2 X No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 No of Vital or Attending Physician: the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Dersing Home 5 - Residence 6 - Other (Specify, 2 200 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ·a 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

		-	For Amend Ite	ms 25,27,28	yland / Depa a-f p er m <i>Cer</i>	tificate of Deatl	n 2011 dhb an Hy h	Reg. No. 0	25529		
	Dissolution	/	1. Decedent's Name (First, Middle, La.	st)			2. Date of De Month		3. Time of Death		
	Physicia Medic		Abraham Johnso				July 26	5, 2011	6:00 A ^M		
	Examin	er	4a, Facility Name (if not institution, give			4b. City, Town, or Location		4c. County of Deat			
the state of the s	F a wal	,	Charlotte Hall V		n yrs. last birthday)	Charlotte If Under 1 Year If Und	der 24 Hrs. 8. Date of Bir	th 9. Birt	hplace (State or Foreign		
ı	Funeral Director		419-12-2995	W □ -	92 Yrs.	Months Days Hour	rs Min. (Month, Da 11/19	/1918 Alal	oama		
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town or Loc	cation			10d. Inside City Limits		
	/arylar 8a-f s tified	Funeral Director	Maryland St. Mar	v's	Charlotte	e Hall			1 ☐ Yes 2xxxNo		
	the Na or 2	Ö	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	ountry?		
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates.	, !	Was Decedent of Hispanic f Yes, specify Cuban, Mexi I ☐ Yes 2 🔀 No Spec		14. Race - Ame Black, White Specify: B1	e, etc.		
5-0	2 hour "natur	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. (Specify only highest grade completed) (Give kind of work done during most of working							Industry		
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Maryland	d be fi	욘	Emmanuel Johnso	n		_ R	osa Steele				
lan	should and N is ma auma		19a. Informant's Name/Relationship (mber or Rural Route Number				
	and 2 lealth em 27 her tr		Sara Alexander/	Daughter	24 20b, Place of Dispo	-	Fredericksb	urg, VA 224			
Baltimore,	Page 1 arment of Hetant: If itel		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	cemetery, crer Maryland	matory or other place) Veterans Cem	08/01/2011	Cheltenham	, Maryland		
Ball	permit Depar Impor any in		21. Signature of Funeral Service Lices	Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield 30195 Three Notch Rd., Characteristics and Address of Facility Brinsfield 2019 Three Notch Rd., Characteristics and Address of Facility Brinsfield 2019 Three Notch Rd., Characteristics and Address of Facility Brinsfield 2019 Three Notch Rd., Characteristics and Address of Facility Brinsfield 2019 Three Notch Rd., Characteristics and Address of Facility Brinsfield 2019 Three Notch Rd., Characteristics and Address of Facility Brinsfield 2019 Three Notch Rd., Characteristics and Address 2019 Three Notch Rd., Cha							
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	cuted ind transit	xam	Cause (Disease or iinjury that initiated events	C	consequence of):		CERTIFICATION APPROVI	D BY MEDICAL EXAMINER			
_	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last	Due 10 (01 23 2 0	55/100440/100 01/3		CERTIFICATION				
3760	ficate g phys			d							
. Box 68	Attending Physician: The law requires that the death certificate be executed ar death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti	Fetal death 3	Ctopic pregnancy Other (specify)		23d. Date of de Month	blivery Day Year		
ls, P.O.	uires that the dea n signed by the a lid be detached f	d by P	Part II. Other significant conditions HIP FR	contributing to death but	not resulting in the t	underlying cause given in F	42	tobacco use contribute t	o the cause of death? Probably 4 Wonknown		
Division of Vital Records,	nysician: The law requires nis certificate has been sig I director, page 2 should b	omplet	ESSENTIA	L HYP	ERTENS	SION	per	formed? death?	utopsy findings available completion of cause of		
a	ian: T ertifica ctor, p	Be	25. Was case referred to medical examiner?				Death (Check only one)				
Ξ	hysic this ce al dire	은	examiner? 1 X Yes 2 D No		at 2 ER/Outpatie		Nursing Home 5 Res		cify)		
n of	ding F h. After funera	sate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, ' on 05/28/20	Year) injury	work?		how injury occurred ct fell.			
isio	To the Hospital or Attending Ph within 24 hours a rer death. To the Funeral Director After the completed filled in by the funeral	Certificate:	2 X Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injury	y - At home, farm, str			(Street and Number or Rown, State) 29449 Road, Charlot	ural Route Number, Charlotte		
ā	Hospital or 24 hours a 6 Funeral Directed filled in	calC	29a. Certifier 1 Certifying Ph	Nursing	g Home	occured at the time, date	and place, and due to the o	ause(s) and manner as s	tated.		
	the Hos hin 24 h the Fun	Medical	(Check 2 Medical Exam	niner: On the basis of exa	mination and/or inves	stigation, in my opinion, dea	ath occurred at the time, date date and place, and due to	and place, and due to the	cause(s) and manner stated.		
_	Vith Vith Con I	-	29b. Signature and title of certifier	0 000		29c. License numb		29d. Date signed (Mon			
			tunley			D006-	1/88	7.26.	2011		
?)			30. Name and address of person who			^{Print)} e Hall, MD 2	0622				
	Sta Registr		31. Date filed (Month, Day, Year) AUG 4 20	22, Registrar'							
	3.36										

	nd #19ap O Health		FD Plea t. 7-26-11 KAH	ase Type or Pri							gible.	
		1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death							25530			
	Physicia Medic	n/	1. Decedent's Name (First, Middle CARYLE	lle, Last)	K	YR.	TAK		2. Date of Dea Month		Year	3. Time of Death
	Examin		la. Facility Name (if not institution Mandrin Hosp				4b. City, Town, or Harwoo	Location of Death	4c. County of Death Anne Arundel			
	Funeral Director		i. Social Security Number 579–48–5484		e (In yrs, last b 76	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 3 / 23 / 1			nplace (State or Foreign hington DC
	the Maryland or 28a-f show e notified at	. 1	Usual Residence of Decedent 10a. State 10b. County Delaware Sussex			y, Town or Location Ocean View						10d. Inside City Limits
		Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Co	1 Yes 2 X No
	th with ns 23a must b	mera	37700 Hickory			140.14	/ D-sadah still	19970	elfu Voe er No	44.0-	A	USA
9800	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	ē	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorced	If Ves Give	No		Yes, specify Cuba	Ispanic Origin? (Spe in, Mexican, Puerto Specify:	Rican, etc.)	Bla	ce - Americk, White	
215-0		Completed	III- DO NOT				ent's Usual Occup ind of work done o NOT use retired)	f work done during most of working Tuse retired)			Kind of Business Industry	
1212		اما		5+	,+,	Atto	rney	19 Mother's Nam	o (First Middle	Lega	_	
Maryland 21215-0036			17. Father's Name (First, Middle, Last) Lockie Cox						Crampt	First, Middle, Maiden Surname) Crampton		
			19a. Informant's Name/Relations Tundee Farre1	TOTAL	e 1	19b. Mailin 34 8	Stanstr	and Number or Rura ate Trail	, Annap	; City or Town, olis, M	State, Zip ID 21	401
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (n 3 Removal from State	ceme	etery, crem	sition (Name of atory or other place e Cremate	ce)	Date 6/2011	20c. Location Balti	-	
Baltii	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		21. Signature of Funeral Service			22	Name and Addre	ss of Facility Joh	n M. Ta ster St	ylor Fu , Annap	nera olis	1 Home , MD 21401
C	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	t only one cause on each line	d the death. De.	E		g, such as cardiac o				Approximate Interval Between Onset and Death
09	Attending Physician: The law requires that the death certificate be executed ar death. sr death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Last (or eac consequence of): C. Due to (or as a consequence of):									
. Box 68760		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 No yes 2 No 9 Unknown 9 Unk								ate of de	llvery Day Year
ls, P.O.												
Division of Vital Records,		Completed							24a. Was autor perfo 1 \(\sum \text{Yes}\)	osy ormed?	prior to death?	topsy findings available completion of cause of s 2 □ No
/ital	ysician; is certific director,	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆 ER	!/Outpatier	Oth	lace of Death (Chec ler: 4 Nursing He		tence 6 70	ther (Spec	MANDRIN
) of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of inju	ıry 28	b. Time of injury	28c. Injur wor	y at k?	28d. Describe			HOUSE
Division		Certificate:								ral Route Number,		
	Hospit 24 hour Funera leted fille	Medical	(Check 2 Medical	ing Physician: To the best of I Examiner: On the basis of ing Nurse Practioner: To the	examination ar	nd/or invest	igation, in my opini	on, death occurred a	at the time, date a	and place, and o	due to the	cause(s) and manner stated.
	To th withir To th	2	29b. Signature and title of certific		St)	29c. Licens		5	29d. Date sign		
	de de		30 Name and address of person	on who completed cause of a		Sa) (Type, F	Print)	20 00 11.	, /h.	m ada ab	l. m	11 7 1/10 1
	Sta Registr		31. Date filed (Month, Day, Year)) 32. Registi	rar's Signature	h. A	aki	med 140	JAMA	Jan	10 [7]	V 1401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Management State of Management State State Registrar		artment of Health a <i>rtificate of Death</i>	nd Mental Hyg F	giene Reg. N2 011 25531			
	Physicia	n/	Decedent's Name (First, Middle, Last)			2. Date of Dea July 21	th 3. Time of Death			
	Medical Examiner Francis N. King 4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of	Death	4c. County of Death			
	_		3255 Patuxent River Road 5. Social Security Number 6. Sex 7. Agr	//n ura laat hirthday	Davidsonville		Anne Arundel 9. Birthplace (State or Foreign			
	Funeral Director		212-32-1099 ¹⅓™ ²□ F 78	1 X M 2 G F 78 Yrs. Months Days Hours Min. 12/21/1932						
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The athand Mental Hygiene with a "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits			
		irect	Maryland Anne Arundel	Davidson			1 ☐ Yes 2 X No	2		
	with the 23a or 1st be n	Funeral Director	10e. Street and Number 3255 Patuxent River Road		10f. Zip Code 21035		10g, Citizen of What Country? USA			
	death items ner m	Fun	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	-		
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 🏋 Married 1 🖫 Yes 2 ☐ If Yes, Give Year or Dates.	№ 1956- 1957	1 \square Yes 2 \overline{X} No Specify:		Specify: White			
21215-0036	"natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of Business Industry			
212	within giene.	To Be	Elementary/Seconday (0-12) College (1-4 or 5	1+)	-employed		Farming	_		
pu	tal Hyg tal Hyg d othe event,		17. Father's Name (First, Middle, Last) Francis D. Chapelle King			r's Name <i>(First, Middl</i> e, i ce Irene Ni				
ız	ould be nd Men marke matic		19a. Informant's Name/Relationship (Type, Print)	19b Mail			r, City or Town, State, Zip Code)			
N S	id 2 sh salth ar n 27 is er trau		Bobbie A. King/Wife				idsonville, MD 21035			
Baltimore, Maryland	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disp cemetery, cre	matory or other place)	Date 7 /06 /0011	20c. Location - City or Town, State			
itim	permit. Page 1 Department of Important: If ii any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee				Davidsonville,MD Kalas Funeral Home	\exists		
B	Dep Imp any		the S. Haly	2	9/3 Solomons 1	sland Rd. E	dgewater, MD 21037	4		
			23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a							
	Physician/ Medical		disease or condition resulting in death) a. Due to (or as	a consequence of):	TE PIGEL	in Leui	Ke.MIA	\neg		
-	Examiner	Į.	Sequentially list conditions, b.							
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	a concequence of;						
	icate be executed physician and s the burial-transit	al Ex	that initiated events c. Due to (or as	a consequence of):						
760	cate be physic the bu	edical	d:							
Box 68760	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth		☐ Ectopic pregnancy		23d. Date of delivery			
. Bo	the att	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	at time of death 5	Other (specify)		Month Day Year			
P.0	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death I	out not resulting in the	underlying cause given in Part I	- 1	obacco use contribute to the cause of death?			
rds,	equires een sig nould b	eted				24a. Was	Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknow an 24b. Were autopsy findings available			
eco	The law rate has b	Completed				autor	psy prior to completion of cause of death?			
a H	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?			th (Check only one)	22310			
Ţ	Physic this corral dire	은	I TOSDILAL	ient 2 ER/Outpatie			dence 6 Other (Specify)			
o uc	ath. r: After	icate	1 Natural 5 □ Pending (Month, De 2 □ Accident □ Investigation		work? M 1 🗆 Yes 2 🗆					
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:		ury - At home, farm, s c. (Specify)	treet, factory, office	28f. Location (\$ City or Tov	Street and Number or Rural Route Number, wn, State)			
Ω	To the Hospital within 24 hours of To the Funeral completed filled	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	the Horthin 24 the Floring the Floring or the Flori	Med	(Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☐ Certifying Nurse Practioner: To the 29b. Signature and title of Cartifier	e best of my knowledge	death occurred at the time, date	and place, and due to the	ne cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)	_		
			mo mo			64852				
	15 6		30. Name and address of person who completed cause of DR - RAVIN GARG-	death (Item 23a) (Type,	Print) DICOL PARKWOY	, SUITE 20	7/22/201) 1 ANNARYS, MODIYK	,1		
	Sta Registr		31. Date filed (Month, Pay, Year) 2011 33 Regist	rar's Signature	all					
	negisti	CII	Value 1	7				_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20ÏI 2:35 August Medical KENNETH EUGENE KING 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick <u>Frederick Memorial Hospital</u> er 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1 X M 2 □ F 8. Date of Birth **Funeral** Months Days Hours 1170471930 217-24-6471 80 Director Mary Land Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ural", or items 23a o Funeral and 2 should be filed within 72 hours after death with 812 Geronimo Drive 21701 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Xes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. Korea the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Postal Service f Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry C. King, Sr. Esther M. Stottlemeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Blanche King / wife 812 Geronimo Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Resthaven Mem. Gardens 8/04/2011 Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home ayelin Kre~ M01222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) sician and burial-transit resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year signed by the a Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 \square Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) D0063498 WADHWA MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15×1 V

DHMH 17 Rev 7/2009

State Registrar Lakhvinder Wadhwa

31. Date filed (Month: Day, Year)

Frederick, md 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25533 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 4:20 PM 2011 <u>Virginia</u> G. Liston 74/4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗷 F Months Hours (Month, Day, Year) 10/25/1927 Ohio Director 579-34-0078 Usual Residence of Decedent 10d. Inside City Limits shov 10a. State 10b. County 10c. City, Town or Location by Funeral Director notified 1 Yes 2 □ No 28a-f MD Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ö be 23a 20715 USA 3903 Claxton Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces Black, White, etc. ò 1 Never Married 2 Married 2 🔀 No Yes 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. Baltimore, Maryland 21215-003 "natural" Completed 3 Midowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private <u>Executive Assistant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ethel Babette Woellner Greaves Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glendale, AZ 85304 West Yucca Street <u> Sharon Bowman - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD incoln Cemetery 7/30/2<u>011</u> 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licensee 23a. Part 1. Eiger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Brentwood, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to lo s a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last nslon Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 4 Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ emit 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗌 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending Accident Investigation Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 52500 leted cause of death (Item 23a) (Type, Print)

JAHABE \$1/8 6 Good Luck ROAD LAN Hom Abd State JUL 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep			1ental Hyg	iene 2011	25534	
			Registrar Amend#17 PerrFHRC08-3-11cr Ce	rtificate of D	eatn	2. Date of Dea	th	3. Time of Death	
	Physicia Medic		STANIEY LANE			JUC4	ZS ZS	1707 M	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death						
and the	Funeral		UNIJERS/TY OF MARTIANO NEOK9/ 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. B	irthplace (State or Foreign	
	Director	ļ	097-36-2306 1 🖁 M 2 □ F 69 Yrs.	Months Days	Hours Min.	JÜLY 2	2 1942 C	NEW YORK	
	nd thow at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	ocation				10d. Inside City Limits	
	Maryla 18a-f tified		MD PRINCE GEORGE'S BOWIE					1 ¥ Yes 2 □ No	
	th the lagarda	al Di	10e. Street and Number	10f. Zip Code	00700		10g. Citizen of What C	Country?	
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. And Tis marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	uner	13319 OLD CHAPEL ROAD 11, Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of His	20720 spanic Origin? (Spe	ecify Yes or No-	14, Race - Am	erican Indian,	
36			Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give	If Yes, specify Cubar 1 ☐ Yes 2 🄀 No	n, Mexican, Puerto	Rican, etc.)	Black, Wh		
9	hours natura lical E	lete	15. Decedent's Education 16a. Dece	16b. Kind of Busines	s Industry				
215	nin 72 ne. ihan "l	To Be Completed by	Elementary/Seconday (0-12) College (1-4 or 5+) life. I	e kind of work done do DO NOT use retired)		ing	DDTIME		
2	ed with Hygier other t		17 Father's Name (First Middle Last)	CAMERA MAI	N 18. Mother's Nam	e (First, Middle,	PRIVATE Maiden Surname)		
auc	be file ental } rked o ic eve		17. Father's Name (First, Middle, Last) ISREAL - LEONARD LANE	i		VASHINGT			
Baltimore, Maryland 21215-0036	12 should be file alth and Mental I 27 is marked o		19a. Informant's Name/Relationship (Type, Print) RUTH RAMSEY-LANE/WIFE 1331	ling Address (Street a	nd Number or Rura	BOWIE, M	; City or Town, State, 2 [ARYLAND 20	Zip Code) 0720	
	1 and of Heal item?	П	20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place	el	Date	20c. Location - City	or Town, State	
<u>E</u>	Page 1 ment of tant: If it ury or o		4 Donation 5 Other (Specify) HARMONY	CEMETERY	7/30/		LANDOVER,		
Balt	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Si priture of Funeral Service Licensee	22. Name and Addres 7474 LAND				RAL HOME, INC. YLAND 20785	
			23a. Part 1. Enter the disease, or compileations that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
	Physician/		Immediate Cause (Final disease or condition					Onset and Death	
regula	Medical Examiner		resulting in death) Due to (or as a consequence of):						
		ińer	Sequentially list conditions, if any, leading to immediate cause. Extended the conditions are consequence of):						
	ate be executed hysician and the burial-transit	Examiner	cause Enter Underlying Cause (Uisease or iinjury that initiated events c						
_	oe exe	dical E	resulting in death) Last Due to (or as a consequence of):						
200	icate by physics the b	ledic	d						
Box 687	aath certifica attending p I for use as I	an/N	IF FEMALE: 23b. Was decedent pregnant 1	☐ Ectopic pregnanc	у		23d. Date of		
Bo	t the death by the att tached for	Completed by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 1 Ves	Other (specify)			Month	Day Year	
0.	es that the signed by be detacl	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ren in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
- S -	requires t been sign should be	ed p				1 🗆	Yes 2 No 3	Probably 4 Unknown	
Division of Vital Records, P.O.	law rec has bee ye 2 sho	nplet				24a. Was autor	osy prior t	autopsy findings available o completion of cause of	
Be	ysician: The la is certificate ha director, page	To Be Con	OF West of the Market State of the Market Stat		45 4 (2)	1 Yes		res 2 No	
/ita	s certif		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpati	Othe	er:		dence 6 Other (Sp	ecify)	
of	ng Phys ter this neral dii		27. Manner Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 1 Natural 5 Pending (Month, Day, Year)	of 28c. Injury	/ at		now injury occurred		
ion	or Attending after death. Director: After in by the funer	Certificate:	2 Accident Investigation		Yes 2 ☐ No	006 1	Street and Number or	Pural Pauta Number	
ivis	after after Direction by		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inve	estigation, in my opinio	on, death occurred a	at the time, date a	and place, and due to th	ne cause(s) and manner stated.	
	To the within 2 To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	29c. License		ice, and due to th	29d. Date signed (Mo		
			Km & Binell	DWG	9506		1214 25, 7	2011	
R	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIM & BIZZEL 22 SWIH GREAVE STREET BACTIONE, IND 21201						
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 8 2011 32. Registra's Signature						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25535 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_{u}^{Month} 2011 Carroll LeBrun 24 7:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 6205 Fairfax Court Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 1 Days Hours April 21, Maryland 75 1936 **Director** 214-92-8743 Usual Residence of Decedent Show 10b. County ms 23a or 28a-f shor must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 X No Maryland Frederick Frederick 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral with 1 6205 Fairfax Court 21701 United States Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Catherine Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Brechbiel/ Caretaker 5736 Industry Lane, Frederick, Maryland 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc.7/25/2011 Frederick, Maryland Signature of Ineral Serv 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike, Frederick, Maryland 2170 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause n each line SEPSIS nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) Day 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 X Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. BOLANUM, MD, 196 TO DM VT repeace MD

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State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25536 Certificate of Death Reg. No. Desedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HTU 50 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Mandrin Hospice House <u>Harwood</u> Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) 6. Sex **Funeral** Months Hours Min. Mar 2 1945 Mary land 66 214-44-1756 Director Usual Residence of Decedent fshow 10d. Inside City Limits ا Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🕅 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 130 Hearne Rd. Apt 611 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes If Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Anne Arundel Co. Clerical event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Glendoline Miller Russell J Moore Sr other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Annapolis, Md. 21401 Dominoe Rd. <u>Greta Johnson(Sister</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2X Cremation 3 Removal from State Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 7-26-11 MNam Rasses of acions Mortuary, 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ I disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, inacing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consequence of the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months
1 Yes 2 No Month Year Day Pregnant at time of death ed by the a detached f Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes 2 N 25. Was case referred to medica 26. Place of Death (Check only one) Be MANDRIN Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ပု 1 Yes 4 Nursing Home 5 Residence s after death.

Director: After this d in by the funeral di 28c. Injury at work? 1 \Boxed Yes 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Gical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 118 100

Registrar

DHMH 17 Rev 7/2009

State

Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item

JENEUTEUE LIGHTFOOFTAYLOR

JUL 2 6 2011

		•	For State Registrar	-	artment of H rtificate of D			g. N2011	25537
	Physicia		1. Decedent's Name (First, Middle, Last) Marian Shriver McS	Sherry			2. Date of Death July 24	, ^D 2011 Year	3. Time of Death 11:30 A м
	Medic Examin		4a. Facility Name (if not institution, give street and r 19 East Second Stre		4b. City, Town, or Freder	Location of Death		4c. County of Dear Frederick	
	Funeral Director		5. Social Security Number 220–22–3648 6. Sex 1 ☐ M 2 🔀	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb 21	9. Bir 1926 Ma	thplace (State or Foreign Juntry) Lry Land
	and show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	he Maryli or 28a-f e notifiec	Direct	Maryland Frederick 10e. Street and Number	Freder	10f. Zip Code		10	g. Citizen of What Co	1 🔀 Yes 2 🗌 No
	ath with tems 23a	Funeral Director	19 East Second Street 11. Marital Status 12. Was D		21 Was Decedent of Hi	701 spanic Origin? (Spe	ecify Yes or No-	U.S.A.	erican Indian,
336	is filed within 72 hours after death with the Maryland Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by F	1 Never Married 2 Married 1 Yes,	res 2 XNo	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, Whit	nite
Maryland 21215-0036	72 hours in "natur Medical B	Completed by	15. Decedent's Education (Specify only highest grade comple	ted) 16a. Dece (Give	dent's Usual Occupa kind of work done o O NOT use retired)			6b. Kind of Business	·
d 212	rould be filed within on Mental Hygiene. I marked other that imatic event, the Mental Mental matic event in the Mental mat	Be Col	Elementary/Seconday (0-12) Colleg 17. Father's Name (First, Middle, Last)	1 Home	emaker	18. Mother's Nam	e (First, Middle, Ma	Own Home	
ıylan	ld be Men arke	2	Clinton Kilty Mac	sherry, Sr	Add (04	Mariar	n Carbe		river
	1 and 2 shou of Health and item 27 is m other traum	385	19a. Informant's Name/Relationship (Type, Print) M. Natalie McSherry,	Daughter One S	South St,	Suite 26	500, Balt	imore, MD	21202-3201
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fi 4 ☐ Donafion 5 ☐ Other (Specify)	from State 20b. Place of Disportant Smithsbut	motory or other plac	al i		Smithsbur	g, Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signatur of Juneral Service Lice Se	MO0706 2	Keeney ai 106 East	hd Basfor Church S	d PA Fund	eral Home erick, MD	21701
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-			diagona or condition						
	Medical Examiner		disease or condition resulting in death) a Due	e to (*) as a consequence of):	Brows +	Prentos			Menth.
	Medical Examiner	niner	if any, leading to immediate cause. Enter Underlying	a to (*) as a consequence of): 1 etc. factor factor e to (or as a consequence of):	breast.	eances			month.
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8760	Medical Examiner	dical	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	e to (or as a consequence of): e to (or as a consequence of):	breast.	cancer			month.
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P,O, Box 687	or Attending Physician: The law requires that the death certificate be executed the death. By Alfactor. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	Certificate: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	e to (or as a consequence of): e to (or as a consequence of): do outcome of pregnancy Live Birth 2 Fetal death 5 Unknown to death but not resulting in the	Ectopic pregnand Other (specify) underlying cause give 26. Plent 3 □ DOA Oth 28c. Injur work M 1 □	ey ven in Part I. ace of Death (Checer: 4 Nursing H	23e. Did tob. 1	Month acco use contribute t s 2 No 3 1 24b. Were a prior to death? 1 Ye nce 6 Other (Spe w injury occurred	Probably 4 Unknown utopsy findings available completion of cause of ess 2 No
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P,O, Box 687	ysician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 mopris? 1	e to (or as a consequence of): e to (or as a consequence of):	□ Ectopic pregnanc □ Other (specify) □ underlying cause give 26. Please 3 □ DOA Other of 28c. Injur work M 1 □ treet, factory, office	even in Part I. ace of Death (Checer: 4 Nursing Heaver and Nursing H	23e. Did tob. 1	Month acco use contribute to see to and Number or Richard Number or Richard State) Month 24b. Were a prior to death? 1	elivery Day Year to the cause of death? Probably 4 Unknown utopsy findings available o completion of cause of es 2 No utility) ural Route Number, tated. cause(s) and manner stated. is stated.
P,O, Box 687	or Attending Physician: The law requires that the death certificate be executed the death. By Alfactor. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	Certificate: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1	e to (or as a consequence of): e to (or as a consequence of):	Ectopic pregnanc Other (specify) underlying cause give 26. Plent 3 DOA of 28c. Injur work M 1 Docured at the time stigation, in my opinis, death occurred at the 29c. Licens	even in Part I. ace of Death (Checer: 4 Nursing Heaver and Nursing H	23e. Did tob. 1	Month acco use contribute to see to and Number or Richard Number or Richard State) Month 24b. Were a prior to death? 1	elivery Day Year to the cause of death? Probably 4 Unknown utopsy findings available ocompletion of cause of es 2 No ecify) ural Route Number, tated. e cause(s) and manner stated. es stated. eth, Day, Year)

		•	For State Registrar	State of Maryland	•	tificate of L		id Wich		eg. N2 0		25538
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	1					ate of Deatl		Year	3. Time of Death
may	Medic	al	Joanne Frances Moul 4a. Facility Name (if not institution, give stre			4b. City, Town, o	r Location of D		Ju1y	23, 2	of Death	12:57 PM
	Examin	er	Crumland Farms Heal	,		Freder					eder	ick
	Funeral Director		5. Social Security Number 6. Sex 1 □ 1	7. Age (In yrs. las		If Under 1 Year Months Days			Date of Birth Month, Day gust 9			lace (State or Foreign ington, D.C.
	bow at	r	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation					1	0d. Inside City Limits
	Marylar 28a-f sl stified	Director	Maryland Frederick			Frederic	k					1 Yes 2 □ No
	n with the	Funeral D	10e. Street and Number 7407 Willow Road			10f. Zip Code	21702			Og. Citizen of V		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	1 Never Married 2 🖾 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🗵 No		? (Specify ` uerto Ricar	es or No- n, etc.)	Blac	e - Americ ck, White, Whi	etc.
15-(72 hor	mple	15. Decedent's Educa (Specify only highest grade of	completed)	(Give F	lent's Usual Occup kind of work done O NOT use retired)	during most of	f working		16b. Kind of B	usiness In	dustry
212	l within ygiene. her tha t, the I		Elementary/Seconday (0-12)	College (1-4 or 5+)	Reg	istered l				Health		
land	l be filec lental H rked otl tic even	To Be	17. Father's Name (First, Middle, Last) Paul Niner				18. Mother's Anna	s Name (Fir	t, Middle, N	laiden Surname) (un	K.)
, Maryland 21215-0036	id 2 should saith and M n 27 is ma er trauma		19a. Informant's Name/Relationship (Туре, William E. Moulden			ng Address (Street Willow R						Code)
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (**pecify)	moval from State 20b. Pla	ace of Dispo Mescha moria	sition <i>(Name of</i> patory or other pla Ven 1 Garden:	s Ju	1y 27,	2011	20c. Location - Frederi	City or To	own, State Maryland
Balt	permit Depart Import any inj once.		21. Signature of Fusion Service Licensee		R 9	Name and Address thaven 501 Cato	Funera ctin Mo	al Ser	vices n Hwy	, Skkot . Frede	. Cod	y P.A. , MD 21701
	Physician/ Medical	es vi	23a. Part 1. Enter the disease, or complications, or heart failure. List only one of Immediate Cause (Final disease or confident from resulting in death)	tions that caused the death ause on each line. Acute Cerebra Due to (or as a conseque	. Do not ente	er the mode of dyir	ng, such as car	rdiac or res	oiratory arre	st,		Approximate Interval Between Onset and Death ays
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	ocupantially list conditions b.								
	cate be executed physician and the burial-transit	al Examiner	Cause (Disease or Injury that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):			_				
68760	ificate by physical physical distribution in the base of the base	Medic	d.									
. Box 68	the Hospital or Attending Physician: The law requires that the death certificate be executed that At hours after death. List and the fact death. The Funerial Director, fact this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transical director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼XNo g ☐ Unknown	If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnan Other (specify)	су				ite of deliv	ery Day Year
ls, P.O.	uires that the signed by ald be deta	ed by Pl	Part II. Other significant conditions control Atherosclerotic Hea		llting in the u	nderlying cause g	iven in Part I.					he cause of death?
Division of Vital Records,	The law require cate has been s page 2 should	Completed by	Degenerative_Disea	se of Lumbar	Spine				24a. Was a autops perform 1 Yes	med?	Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
ita	sician: The certificate rector, pag	Ba	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hos	pital:		Ott	Place of Death (
of V	ng Phys ter this neral di	te: To	27. Manner of Death 1 🛣 Natural 5 🗆 Pending	1 Inpatient 2 E 28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	IT 3 LI DOA	4 K J Nursi ry at			ence 6 Oth ow injury occurr		/)
vision	l or Attending PP after death. Director: After th I in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		M 1 🗆	Yes 2 No	_	Location (St City or Town		er or Rura	I Route Number,
	ospital o	Medical C	29a. Certifier 1 2 Cartifying Physicia	ın: To the best of my knowle	edge, death o	occured at the time	e, date and pla	ace, and du	e to the cau	se(s) and mann	er as state	ed.
	To the Hospital or a within 24 hours after To the Funeral Dire completed filled in bire that the fille	Med	(Check 3 Midical Examiner 3 Graphine Number 29b. Signature and title of certifier	On the basis of Astrination	and/or invest	death occurred at the	he time, date ar	irred at the t	d due to the	cause and m	anner as s	tated.
A	5 ≥ 6 8		230. Signature and therpoi certifier	_ / /	Mi	29c. Licens		79	- 1	29d. Date signe. July 2 6		
	5		30. Name and address of person was com Casper E. Clin., M			Street,	Frederi	ick, l				
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure .	barke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25539 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ₾2011 Physician/ 4:00 P M July 31, Anna Mae Murphy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 15525 Scout Camp Road Hughesville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours August 26,1925 Maryland 213-22-2352 85 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2X No Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15525 Scout Camp Road 20637 United States items 2 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Examiner Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Food Service Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Wood Canter Marguerite Cecelia Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau PO Box 55, Mechanicsville, MD 20659 Pat A. Stone/Daughter 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Mary's Church 4, 2011 Bryantown, MD Aug. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Line Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch RD., Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Pi Physician/ disease or condition Medical resulting in death) Jas arlae Accident **Examiner** 25 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examin physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ending pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available 24a. Was an s certificate has b director, page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 2 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify this funeral 28a. Date of injury (Month, Day, Year) Manner of De 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1—Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

AUG

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		State of	Marylan	-	irtment of F tificate of D		Mental Hy	giene Reg. 201	1	25540
	Physicia		1. Decedent's Name Ellis	(First, Middle, Las Emmitte	,	ain				2. Date of De Month August	eath Day		3. Time of Death 1:00 A M
	Medic Examin		4a. Facility Name (if n		street and numbe			4b. City, Town, or			4c. County	of Death	
ر	Funeral		5. Social Security Nur	nber 6. Se		Age (In yrs. la	st birthday)	Frederi If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Bir	Frede	g. Birth	place (State or Foreign
	Director		215-34-376 Usual Residence of D		ZM 2 LI F	73	Yrs.	Worth's Bays	Tiodis IVIII	Aug. Z	8, Yea 1937	Mar	y Land
	ryland -f shov ied at	Director	Tour Grand	10b. County F rederi c	k		, Town or Loc ertyto						10d. Inside City Limits 1 ☐ Yes 2 🛣No
	the Ma or 28a e notif		10e. Street and Numb			101.0	CLCyc	10f. Zip Code		-	10g. Citizen of V	Vhat Cou	intry?
	h with ns 23a nust b	Funeral	11934 Nor	th Stree			1	21762			United		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	5	11. Marital Status1 Never Marrie3 Widowed 4		12. Was Decede Armed Force 1 X Yes 2 If Yes Give Year or Date	es?	lf If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)	Blac	k, White, Whi	ican Indian, , etc. .te
15-0	72 hou in "natu Medica	Completed		15. Decedent's Enify only highest gra	ade completed)	- 1	(Give k	ent's Usual Occup ind of work done of NOT use retired)		orking	16b. Kind of Bu	ısiness Ir	ndustry
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land	l be filed lental H rked ot tic ever	면 명	17. Father's Name (Fi		Sr.					Naomi R	, Maiden Surname unkles		
Baltimore, Maryland 21215-0036	should hand N 7 is ma trauma		19a. Informant's Nan Dennis Ma		/pe, Print) (Son)			g Address (Street a					
re,	1 and 2 of Healt item 2		20a. Method of Dispo	osition	<u> </u>		lace of Dispo	sition (Name of natory or other place		Date	20c. Location -		
timo	t. Page tment c rtant: If ijury or		4 Donation	Cremation 3 5 5 Other (Special	ý)		asant I	Hill Ceme	tery 8	/8/2011			Maryland
Ba	permit Depar tmpor any in		21. Signature of Fund	11.	eee H	MO1612		e eney d@drE 06 E. Chu	asford irch Str	P.A. Fun eet, Fre	eral Hom derick,	e Mary	land 21701
-	nysician/ Medical Examiner)r	Immediate Cause (F disease or condition resulting in death)	failure. List only o inal ditions,	a. Due to (or	a line.	rence of):	er the mode of dyin			rrest,		Approximate Interval Between Onset and Death
09.	cate be executed physician and s the burial-transit	edical Examiner	if any, leading to imr cause. Enter Under! Cause (Disease or II that initiated events resulting in death) Li	ying njury	C	as a consequ							
P.O. Box 68760	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?		irth 2 🗆 Feta ant at time of c	ıldeath 3 ⊑	Ectopic pregnand Other (specify)	су			te of deli	ivery Day Year
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Vita	ysiciar is certif directo	To Be	25. Was case referre examiner? 1 Yes 2		Hospital:	patient 2 🗆	ER/Outpatier	Oth	er: 4 Nursing	, ,	idence 6 🗌 Oth	er (Speci	ify)
ion of	I or Attending Physician; The la after death. Director: After this certificate he in by the funeral director, page	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investigatio 6 ☐ Could not be	n	, Day, Year)	28b. Time of injury	M 1 □	y at ⟨? Yes 2 □ No		how injury occurr		
Divis	al or Att s after d l Direct d in by		4 Homicide	determined	28e. Place o	f Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, str	eet, factory, office			(Street and Numb wn, State)	er or Rur	al Route Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completed filled in	Medical	(Check 2	Medical Exam	iner: On the basis	of examination	n and/or inves	occured at the time tigation, in my opini death occurred at th	on, death occurre	ed at the time, date	and place, and du	e to the c	cause(s) and manner stated.
	No the Control		29b. Signature and t	itle of certifier	6			29c. Licens			29d. Date signe		n, Day, Year)
			30. Name and addre	ss of person who	completed cause	of death (Item	1 23a) (Type, F	Print)	level M	1 2170	71.		
V	Sta Registr		31. Date filed (Month	UG 1 0 2	32.	istrar's Signa							

DHMH 17 Rev 7/2009

lasmine Yvonne C	1	- For State	tate of M	aryland /		tment of	Health an	d Menta	al Hyg		a No	201	-	25541
Physician		te gistrar 1. Decedent's Name (First, Midd	lle,Last)				200			Date of Deat		Vere	T	3. Time of Death
Medical Examine		Jasmine Y. (Owens							Month July 23, 20		Year		0338 hrs
	•	4a. Facility Name (if not instituti Eastbound Route 50		and number)		(tb. City, Town, or	Location of	Death			nne Arur		
	٩,								3 Date of Birt				hplace (State or	
Funeral Director	ľ	5. Social Security Number	6. Sex		(in yrs. ias		If Under 1 Yea Months Day		Min.			1 F	oreigi	n
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Au a		10a. State 10b. County			10c. City, To	own or Locati	on							10d. Inside City Limits
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5-0036 ed within 72 hours aft by giene. other than "natural" the Medical Examina Commoleted by		Elementary/Secondary (0-12)		llege (1-4 or 5		during me	ost of working life	DO NOT us	se retired)				,
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IVISION Of ' or Attending Ph after death. Director: After t in by the funeral	<u> </u>	2 Accident Inve	stigation	e. Place of Inju	ury - At hom	ne, farm, stree	t, factory, office b		an	d was stru f. Location (S				al Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:			old not be ermined (S	pecify) Maj	or Road	/ Highway		•	Ea	or Town, St stbound Ro	ate) ute 50	MM 20, A	nnap	oolis, MD
Hosp 24 hov Funer stely fi		29a Certifier	hysician: To	the best of my	knowledge	, death occur	red at the time, da	ite and place	e, and du	e to the cause	e(s) and	d manner as	s state	d.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buardical Certification: To Be Completed by Physician/Me	B	one) 2 Medical Exa	and ma	basis of exam anner stated.	nination and	/or investigati	ion, in my opinion		irred at th	ne time, date a				
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		Hamete & Vru	thall,	MU			O.C.I	vi.⊑.			July	23, 2011	·	
4		30. Name and addr-ss of person Pamela E. Southall, I	-	ed cause of de stant Medic			W. Baltimore	e Street	Baltim	ore MD 21	223			
State	e :	31. Date filed (Month, Day, Year)		32. Registrar					-uniii(
Registra	2.7	JUL 2 6	3 2011	Bear	1 1	1 pa	Kel							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25542 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULT ^D2011 Physician/ 3:21 P 21 LEVI PRESCOTT Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CAPITOL HEIGHTS 4305 WILL STREET 9. Birthplace (State or Foreign 8. Date of Birt . Social Security Number 6. Sex 1 XM 2 ☐ F If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** MAY 1942 SOUTH CAROLINA 248-60-4428 69 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State death with the Maryland Examiner must be notified at Director 1 X Yes 2 No PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10e. Street and Number Funeral 23a USA 20743 4305 WILL STREET items (13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ■Yes 2 □ No ARMY Black White, etc. 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examiran injury or other traumatic event, the Medical Examirans in the Medical Examirans in the Medical Examiration or other traumatic event, the Medical Examiration in the Medical Examirati þ BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) SUPERVISOR GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ MAZARENE YATES EDWARD PRESCOTT SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4305 WILL STREET CAPITOL HEIGHTS, MARYLAND 20743 GLADYS L. PRESCOTT/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Parial 2 Cremation 3 Remo CHELTENHAM, MARYLAND VETERANS CEMETERY 7/28/2011 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Fune Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a, Part 1. Enter the disease, or complicate shock, or near failth. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 1 ☐ Yes 2**y**☐ No 1 ☐ Yes 2 ▼ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 K No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 5 Pending 1 Yes 2 No after death Director: A d in by the fi Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft

To the Funeral Dir

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 27, 2011 D46520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

GERARD HARRIS M.D.

106 IRVING STREET N.W. WASHINGTON, DC 20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25543 1 - State Registrar Reg. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 2011 13:34 PM FRANK BENJAMIN PAYNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ELKTON CARE AND REHAB CECIL ELKTON Social Security Number Sex 1 XXM 2 🗆 If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours Min. (Month, , *Day, Year* 16, I Director 212-42-6296 74 FEB. Ĩ937 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 ☐ Yes 2 🎖 No MARYLAND CECIL CHARLESTOWN 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ö ms 23a or must be r Funeral 1721 WEST OLD PHILADELPHIA ROAD 21914 UNITED STATES ral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11, Marital Status Armed Forces?
1 ☐ Yes 2 XXNo Black, White, etc þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: WHITE If Yes, Give Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) AUTOMOTIVE Elementary/Seconday (0-12) College (1-4 or 5+) ASSEMBLY LINE 8 MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ STANFORD I. PAYNE, SR. ANNA ELIZABETH BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Enarlestrown: 1721 WEST OLD PHILADELPHIA ROAD BARBARA O. PAYNE / SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State JULY128, NORTH EXSTORED CEMETERY 1XX Burial 2 Cremation 2 Removal from State NORTH EAST, MARYLAND 4 Donation 5 D Other (Specify) 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 21. Signature of 50 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the isstase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or s a consequence Examiner conce: Sequentially list conditions, as a consequence of): cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 No After this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniurv 5 Pending Natural Accident work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical

24 hours after death Funeral Director: / completed within 2 To the F

State

Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who com

28 201

eted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date-signed (Month, Day, Year

29c. License number

Examiner Maryland 21215-0036

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at
--

Physician/

Medical

For State Registrar

5. Social Security Number

286-38-7389

10e. Street and Number

11. Marital Status

MD

Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

.ERIE

10b, County

2506 Davidsonville Road

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

Alfred Scheiderer

Evan Rees (spouse)

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

1 🗆 M 2 🔽

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

1 🔲 Burial 2 🗶 Cremation 3 🗆 Removal from State

67

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

College (1-4 or 5+)

If Yes Give

Year or Dates

10c. City, Town or Location

Gambrills

Baltimore,

Ray 68760

			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		th. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
- 1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a CHRON	IC 6	BSTRUC	TIVE		Unset and RathS
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or a) c	quence of):	DISEA	SE		
2	te be e hysicia he buri	dical		d					
DO / 00 X OO .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🔲 Ectopi			23d. Date of de Month	elivery Day Year
, .	es that th signed by I be detac	d by Ph	Part II. Other significant conditions co	ontributing to death but not re	esulting in the underlying	g cause given in Part I.			o the cause of death?
Records,	he law requir te has been age 2 should	Completed			,		24a. Was an autopsy performed:	prior to death?	utopsy findings available completion of cause of
=	an: T tiffica tor, p	Be C	25. Was case referred to medical			26. Place of Death (Che		1101	
Z C	/sicis	To B	examiner? 1 🗆 Yes 2 🗀 ¥6	Hospital:	☐ ER/Outpatient 3 ☐	DOA Other:	Home 5 Residence	6 Other (Spec	cify)
sion or	nding Phy ath. r: After this e funeral o	Certificate: T	27. Manner Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inj		
JINISI	al or Atte s after des Il Directo	l Certif	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci		pry, office	28f. Location (Street and City or Town, Sta		ıral Route Number,
	ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2 Medical Exami	sician: To the best of my kno iner: On the basis of examinati se Practioner: To the best of r	on and/or investigation, i	n my opinion, death occurred	at the time, date and pla	ice, and due to the	cause(s) and manner state
			29b. Signature and title of certifier	00 5	[P 2	9c. License number	29d. I	Oute signed (Mont	h, Day, Year)
	2180		30. Name and address of person who	ightfact-TA	ylor CKAP	445 Defer	se Hwy	ENNAPO	115 MD 2140
	Sta Registra		31. Date filed (Month, Day, Year) JUL 26 20	32. Registrar's Sign	A. Sax	v '			
DHI	VIH 17 Rev 7/20	09			. ,				
					ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Annapolis

10f. Zip Code

1 Tes 2 No

Secretary

20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crematory

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

21054

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Days

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Min.

Reg. NZ U

Year

Anne Arundel

9. Birthplace (State or Foreign Country) hio

10d. Inside City Limits 1 Yes 2 X No

2011

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business Industry

20c. Location - City or Town, State

Glen Burnie, MD

Publishing

Specify

USA

White

14. Race - American Indian,

2. Date of Death

8. Date of Birth

18. Mother's Name (First, Middle, Maiden Surname)

Marie Scheiderer

Date

7/23/2011

12 Ridgely Ave. Annapolis, MD 21401

22. Name and Address of Facility Hardesty Funeral Home P.A.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Davidsonville Rd. Gambrills, MD 21054

0172071944

Month O

11-05498 Diamond Janay Re		ase Type or State of	Print in Blac l f Maryland / D	k Indelible epartment (Certificate (of Health a	re All Copic nd Mental H	ygiene		2011	2554
Physician Medical Examine	Registrar 1. Decedent's Name	Diamond	Janay Ree	eves	or Death		2. Date of De Month July 23,	ath Day 2011	Year	3. Time of Death 1138 hrs
	4a. Facility Name (if PG Hospital	Center			Cheverly	or Location of Death		Prir	ounty of Death	
Funeral Director	5. Social Security Nu 213-91-10 Usual Residence of	655 _{1 M}	- T	yrs. last birthday)		Hours Mir	_	,	Foreig	washington D.C.
nd show any		Ob. County		. City, Town or Loc	ation 1 Height	s				10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Num	rchmont Av				743		Unite	of What Cour	es
	11. Marital Status 1 X Never Marrie 3 Widowed	_	2. Was Decedent Ever Armed Forces? 1 Yes 2 X Yes, Give Year	1	Was Decedent of H f Yes, specify Cub Yes 2 X N	Hispanic Origin? (S an, Mexican, Puerto to specify:	pecify Yes or N Rican, etc.)		White, etc.	ican Indian, Black, \mathbf{ack}
72 hours after a "natural" al Examine:		ucation (Specify only	r Dates: highest grade complet College (1-4 or 5+)		tent's Usual Occup most of working li	pation (Give kind of fe. DO NOT use ret		16b. Kind	d of Business/I	ndustry
5-0036 lied within 72 hour Hygiene. d other than "natt the Medical Exam	None 17. Father's Name (I		Doors a		Infant —	18.Mother's Name	e (First, Middle			
by 21214 should be fill and Mental F 7 is marked natic event, 1	19a. Informant's Nar		Reeves e, Print) Payne (Moth			eet and Number or	Rural Route N	umber, City	or Town, State	e, Zip Code) 20743
ages 1 and 2 and 2 nt of Health 2 other traum	20a. Method of Disp	osition Cremation 3	Removal from State	20b. Place of Disp crematory or	oosition (Name of o other place)	cemetery	.8,2011	20c. Loc	cation - City or	Town, State Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other th	4 Donation 5 Signature of Fur	ne la ce Licens	mark	22 LT	2. Name and Address	ess of Facility R . Kennedy S	treet,N	ton Co	ompany ashingt	Morticians ton,D.C.200
Physician /Medical Examiner	failure. List only Immediate Cause (F	y one cause on each Final disease a. S 1	udden Unex	plained I				errest, shock	, or heart	Approximate Interval Between Onset and Death
	or condition resultin Sequentially list cor if any, leading to im	nditions, b mediate Du	ue to (or as a conseque ue to (or as a conseque							
ted Innsit	cause. Enter Under (Disease or injury the events resulting in o	nat initiated C.	ue to (or as a conseque	ence of):						-
60, nte be executed hysician and e burial - transi	W UNPENDED		AMENDED 23a, 2		per me,g	919 9-9-1	1 sm	23d. I	Date of deliver	у
that the death certificate be executed that the death certificate be executed ted by the attending physician and detached for use as the burial - transi	23b. Was decedent past 12 months 1 Yes 2 V	?	1 Live birth 4 Pregnant at time 9 Unknown	e of death 5	Fetal death : Other (Specify)	Ectopic pregn	ancy	М	onth I	Day Year
P.O. E res that the d signed by the be detached	1	ficant conditions	ontributing to death bu	it not resulting in th	ne underlying caus	e given in Part I.	1.0	_	e contribute to	the cause of death? bably 4 Unknown
Records, The law requires ficate has been sig, page 2 should be							per	as an copsy formed?		utopsy findings available completion of cause of es 2 No
Division of Vital Records, P.O. Box 68760, at or Attending Physician: The law requires that the death certificate be a fire death. In Director. After this certificate has been signed by the attending physicial with the funeral director, page 2 should be detached for use as the burners.	25. Was case referrexaminer?	2 No	spital: 1 Inpatient	2 🖊 ER/Outpati	ent 3 DOA		ing Home 5	Residenc		r.
Division of real or attending Piral real or attending Piral real real real real real real real r	27. Manner of Death 1 Natural 2 Accident	h 5 Pending Investigation	28a. Date of Injury (Month, Day, Year) fd 7-23-	11 fd 10	:30 am 1	njury at Work? Yes 2 X No	28d. Describ	m		ural Route Number, City
Division tal or Attendii rs after death. al Director: A led in by the fu	3 Suicide	6 Could not be determined	28e. Place of Injury (Specify)	r-At home, farm, s Reside 1		e building, etc.	or Town	, State) 1	13 Larc	hmont Ave.

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for us Physic Completed by å Certification:

IF FEMALE:	23c. If yes, outcome of pregnancy		23d. Date of	delivery	
3b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month	Day	Year
·	4 Pregnant at time of death 5 Other (Specify)				
1 Yes 2 V No 9 Unknown	9 Unknown				
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contri	ibute to the cause	of death?
		1 Yes	2 🗸 No 3	Probably 4	Unknow

Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ✔ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 Natural 1 Yes 2 X No Unknown 5 Pending fd 7-23-11 fd 10:30 am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1113 Larchmont Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide Residence determined Capitol Heights, Md. Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one one of the cause of the ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) July 24, 2011

30. Note and with ss of person who completed cause of death (Item 23a)

and manner stated.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 31. Date filed (Month, Day Year) AUG 0 5 2011

State Registrar

Medical

Io the Hospital or Attending Physician: The law requires that the death

			For State	State of Maryland				∕lental Hy	giene	011	25546
			Registrar 1. Decedent's Name (First, Middle, Las	<u>t</u>)	Cen	ificate of D	<i>peatri</i>	2. Date of De	Reg. No.		3. Time of Death
	Physicia Medic		Jazzlyn C	Aloe Sellm	an			Month	Day	2011	1035 M
	Examin		4a. Facility Name if not institution, give	street and number) Medical Cent	£.R.	4b. City, Town, or	Location of Death		1 1	County of Deal	rundel
	Funeral Director		5. Social Security Number 6. Solution 6. S	PX 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da	th Sy Year 20	9. Birth	nplace (State or Foreign Intry) Kyland
			Usual Residence of Decedent	100 City	Town or Loc	ation	7 ~				10d. Inside City Limits
	laryland 3a-f sh tified a	Director	10a. State 10b. County	corges Car	2:42)	Heien	hts				1 Yes 2 □ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral Di	10e. Street and Number			10f. Zip Code	1-2		-	ren of What Cou	untry?
	items 2	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Ongin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White	
036	rs after or ral", or Examir	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🙇 No If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:		s	Specify: Bl	ack
5-0	72 hou "natu edical	Completed	15. Decedent's E (Specify only highest gra		(Give k	ent's Usual Occupa ind of work done d NOT use retired)	ation Juring most of work	ring	16b. Kir	nd of Business I	ndustry
212	within glene. er than the M		Elementary/Seconday (0-12)	College (1-4 or 5+)		ONE			1	VONE	
Maryland 21215-0036	be filed ental Hyg ked oth ic event,	To Be	17. Father's Name (First, Middle, Last)	Sellman	3R		18. Mother's Nam	1 1	1	urname)	Smith
lary	2 should I Ith and Me 27 is marl traumati		19a. Informant's Name/Relationship (7)	pe, Print)	19b. Mailin	g Address (Street a					Code)
	and 2 Health tem 27		Sohn Sellman 20a, Method of Disposition	TOUT CITY	7203	Stract Sition (Name of	udo a	Date Date	20c. Lo	Height cation - City or	Town, State
Baltimore,	Page 1 nent of ant: If it ury or c		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	netery, crem	atory or other place rary UMC		2-11	Ar	nold,	Md.
Balt	permit. Departn Importa any inju		21. Signature of Funeral Service Licens	see		Imame an Reseas 922 For				_	
ı			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the death. ne cause on each line.						. 0	Approximate
~	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Co	urger	utal A	nomalis	5-IRIS	omy	18	Onset and Death
	Examiner	L	Sequentially list conditions,	b. Enderhal	loco.	ele)		
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as conseque	nce of):	7					
	ate be executed hysician and the burial-transit	el Exa	that initiated events resulting in death) Last	c. Due to (or as a conseque	nge)of):	10/Dal	+				
200	cate be physici s the bu	edical	•	Id. Ventral -	Je pre	al Dela	<u>cl</u>				
Box 687	eath certificat attending ph I for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	death 3 🗌	Ectopic pregnanc	:y		2	23d. Date of del Month	livery Day Year
. Bo	he deatl y the atl ched fo	hysici	1 Yes 2 No 9 Unknown	4 Pregnant at time of de	ath 5	Other (specify)				MOILLI	Day lear
, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did		~	the cause of death?
ords	w require s been si should I	pletec					<u> </u>	24a. Was	s an	24b. Were au	topsy findings available completion of cause of
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/ital	sician s certifi lirector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 🗆 E	R/Outpatien	Othy	er:	ok only one)	idence 6	Other (Spec	ify)
of \	ing Phy i. Viter this uneral c		27. Manner of Death		8b. Time of injury	28c. Injury work	y at	28d. Describe			
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined		ne, farm, stre		Yes 2 □ No		(Street and	Number or Ru	ral Route Number,
2	pital or ours aft eral Dit filled in		29a. Certifier 1 Certifying Phy	sician: To the best of my knowled	dge death o	occured at the time	date and place, a	li .		d manner as sta	ated.
	the Hos nin 24 h the Fun	Medical	(Check 2 Medical Exam	iner: On the basis of examination see Practioner: To the best of my l	and/or invest	igation, in my opinio leath occurred at the	on, death occurred e time, date and pla	at the time, date	and place, he cause(s	and due to the and manner as	cause(s) and manner stated. stated.
	To with		29b. Signature and title of certifier	Cear in		29c. License			29d. Dat	e signed (Mont)	n, Day, Year)
	1			completed cause of death (Item 2		rint)		afo 13	M		
	Sta	te	31 Date filed (Month, Day, Year)	32. Registrar's Signatu	Medi-	cal Fran	by AIR	yous,	, , ,,	5.70	
	Registr		JUL 262	UII Seneur	p. 4	ack					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Dav Physician/ 2011 07 ANTHONY C. SWIDER Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 931 EDGEWOOD ROAD, APT# 208 ANNE ARUNDEL ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Numbe **Funeral** 1 🗶 M 2 🗆 F Months Month Day Year 30 PA 80 Director 179-22-1247 Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 🙀 Yes 2 🗌 No ANNAPOLIS MD ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral 21403 USA 931 EDGEWOOD ROAD, APT# 208 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner rmed Forces?
XYes 2 No Black, White, etc ģ ō 1 Never Married 2 Married 1 🗆 Yes 2 🗶 No Specify: If Yes, Give Year or Dates 1951-1952 Specify: WHITE "natural", Completed 3 ▼ Widowed 4 □ Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "na any injury or other traumatic event, the Medic once. College (1-4 or 5+) Elementary/Seconday (0-12) 12 AUTO SALES OWNER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ **ELEANOR PUSCIZNA** MICHAEL SWIDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KELLY COURT ANNAPOLIS, MD 21403 GAILE JONES / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 07/29/2011 SPRINGFIELD, PA 4 ☐ Donation 5 ☐ Other (Specify) STS. PETER & PAUL 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS LIFENBEIN & NEWNAM CREMATION & FUNERAL CARE, PA 814 BESTGATE RD. ANNAPOLIS, MD 21401 Signatur Funeral Service Lic or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease shock, or heart failure. Li Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mony disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of than, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) been signed by the should be detached 9 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director and filled in by the f autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \square Yes 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 🗌 No

Baltimore, Maryland 21215-0036

who completed cause of death (Item 23a) (Type, Print) . 0 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Accident

Suicide

3 E

29b. Signature and title of certifier

4 Homicide

29a. Certifier

(Check

Medical

Investigation

determined

6 Could not be

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 4/13th 1924 (ar) Hours 1 🕅 M 2 🗆 F Washington, DC 82 **Director** 228-30-4518 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🌡 No Anne Arundel Crownsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21032 86 Summer Hill Park within 72 hours after death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 1 Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Year or Dates the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) during most of working (Give kind of work done of life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Builder Self-employed 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Crandal1 ဂ္ Mabel G. В. James Smarr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6114 Dinwiddie St. Springfield, VA 22150 Harold G. Smarr, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem'l Gardens 7/26/2011 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signature A Funeral Service Licenses plu cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part . Enter the disease, or compli shock, or heart failure. List only on Onset and Death Immediate Cause (Final Physician/ pilation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examine Ken MUSS burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 - ER/Outpatient 3 - DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Datę signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

262011

MA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 824 PM Year Month Physician/ Diane Dranks 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9/1/1944 Washington, 1 □ M 2 👿 F 66 213-40-9101 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marked. 10b. County 10c. City, Town or Location 10a State Funeral Director 1 Yes 2 No Edgewater Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 USA 1632 Hilltop Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11, Marital Status Armed Forces? Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary Elizabeth Healy John Joseph Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6112 Granby Rd. Rockville, MD 20855 James R. Allen/Brother 20a. Method of Disposition
1 ☐ Burial A Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or othe
Kalas Crematory 7/23/2011 Edgewater, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Rome 21. Signatu ale 2973 Solomons Island Rd. Edgewater, MD21037 t + t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Enter the diseas or complication k, or heart failure. List only one cau Immediate Cause (Final disease or condition Pancreali Physician. years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown has been signed by the e 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate 2 X No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 2 No ပ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 14 2003 31. Date filed (Month, Day, Year) State 26 2011 JUL Registrar

		1	For State of Maryland	/ Department of Health and I Certificate of Death	Mental Hyglen Reg. 1	
	Physicia		1. Decedent's Name (First, Middle, Last)	Smith	2. Date of Death	Pay 2011 12:17 P M
4	Medic Examine		WAYNE 4a. Facility Name (if not institution, give street and number) I VISTA MEDICAL CENTER	4b. City, Town, or Location of Death		4c. County of Death CHARLES
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last 212 - 90 - 8163 1 M 2 F 52		8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
7	Director	ļ	Usual Residence of Decedent	own or Location		10d. Inside City Limits
1	Marylan 28a-f sk otified a	irecto	Maryland Charles Wal	dorf		1 ☑ Yes 2 ☐ No Citizen of What Country?
7	with the s 23a or ust be n	eral D	2342 Mailcoach Ct	10f. Zip Code 2060 l		USA.
LA 9	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Fun	11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
Z 00-9	hours af natural", lical Exa		3 Wildowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	rking 16b	b. Kind of Business Industry
2/E	vithin 72 liene. er than "l the Mec	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired)		oring Dell Center
/A/	be filed v ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Unkinsun	18. Mother's Nai	me (First, Middle, Maid Ruse M	en Surname) Washinton
Zar.	1 and 2 should be the Health and Men then 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ural Route Number, City	v or Town, State, Zip Code)
H. J.	e 1 and 2 of Healt If item 2 or other 1		20a Method Disposition 20b Pla	ce of Disposition (Name of	Date 200	c. Location - City or Town, State
MITA Baltimore	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service (Icensee	22. Name and Address of Facility	27-11 6	Jaldu & MT)
W.	an)	0 3	23a, Part 1. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac	c or respiratory arrest,	Approximate Interval Between
	Physician/	6 0	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	MASSIVERYULW	rondon	Opent and Death
	Medical Examiner	Ļ	Sequentially list conditions.	ENTE (SUPLING)	is with	DERDING-THRE
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that infliated events c.	ice of):		
0	ate be executed physician and the burial-transit	edical Ex	resulting in death) Last Due to (or as a conseque	nce of):		
68760	eath certificate attending phy for use as the		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	× ====================================		23d. Date of delivery
Box	e death o the atten hed for u	Physician/M	in the past 12 months? 1	death 3 ☐ Ectopic pregnancy ath 5 ☐ Other (specify)		Month Day Year
PO		ě	Part II. Other significant conditions contributing to death but not resul	ting in the underlying cause given in Part I.	UII.	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Becords	law requir nas been 2 should	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
R P	ian: The l	Be Con	25. Was case referred to medical examiner?	26. Place of Death (Ch	1 🗆 Yes 2	No 1 Yes 2 No
J. Vit	physicier this ceeral direc	은	1 Yes 2 No 1 Inpatient 2 E	R/Outpatient 3 DOA Other: 4 Nursing 28b. Time of injury at work?	Home 5 Residence	e 6 Other (Specify) injury occurred
ojo n	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hon	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
į	spital or lours afte	cal Ce	building, etc. (Speciny)	dge, death occured at the time, date and place	and due to the cause(s) and manner as stated.
	the Hoithin 24 h	Med	29a. Certitier (Check conly one) 3 Certifying Physician: to the basis of ray mination only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	and/or investigation, in my opinion, death occurred	d at the time, date and p place, and due to the car	place, and due to the cause(s) and manner stated.
	To with		Huz Wal	n) D 20C	29.	7/19/11
	362		30. Name and address of person who completed cause of death (Hem.	AM WW MA	LDORF	-, md 50803
	Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Signatu	B. parl		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25551 State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20 Carolyn Jean Sowell 9:59 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5603 San Juan Drive Clinton Prince George's Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min 66 Director 215 44 5481 Dec Washington DC Usual Residence of Decedent show 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ☐ Yes XX No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5603 San Juan Drive United States 20735 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11, Marital Status Armed Forces?

1 Yes 2 WNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security D.O.D. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert lee Davis Elinor Jean Hull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis D. Williams III (Son) 6620 Woodland Road, Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory July 23, 2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications text caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in tips agents.) Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burialnding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the hed ed by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed Yes 2X certificate 2**X** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 XXResidence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 \square Pending 1 Tyes 2 🗌 No n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 3 Signature and title c. License number 29d. Date signed (*Month*, *Day*, *Year*) ne and address of person who completed cause of death (Item 23a) (Type, Print)

Ivan Zama, MD 9200 Basil Court, Suite 200, Largo, MD 20774 31. Date filed (Month Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

JUL 25

		-	For State Registrar	State of Ma	-	partment of Hea ertificate of Dea			eg. No. 2011	25552	
	Physicia	n/	1. Decedent's Name (First, Middle	,				Date of Deat Month	h Day Year	3. Time of Death	
	Medic Examin	al	Angelia Mari			4b. City, Town, or Loc	cation of Death	07	21 2.011 4c. County of Dea		
لمديد	LAMIIII		JENINSULA REGIL	Was Medical	Center	SAL	136419			DMICO	
١	Funeral Director		5. Social Security Number 213-90-9738	6. Sex 7. Age	(In yrs. last birthda Yrs	Months Days H	f Under £4 Hrs. Hours Min.	8. Date of Birth 6 – 1 4 – 1	966 MD	thplace (State or Foreign ountry)	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	Maryla 28a-f s otified	Director	MD Wicor	mico	Salisbu	ry				1 ☐ Yes 2 X No	
	th the 3a or t be no		10e. Street and Number	- 7 - 1 - 6	. 0.6	10f. Zip Code		10g. Citizen of What Country? USA			
	eath wi	Funeral	1302 Jersey I 11. Marital Status	12. Was Decedent E		21801 3. Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spec	ify Yes or No-	14. Race - Ame		
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Voc Give	No	1 Yes 2 No S		ican, etc.;	Black, Whit		
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212	within rgiene. ner than t, the N		Elementary/Seconday (0-12)	College (1-4 or 5		ectronic Te	ech		K&L Micro	wave	
and	uld be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, and Billy Shoffne			ŀ	8. Mother's Name Carolyn	•			
ary	should be fill and Mental is marked or aumatic eve		19a. Informant's Name/Relations			ailing Address (Street and	i Number or Rural	Route Number,	City or Town, State, Z		
e, N	and 2 s Health s tem 27 i		Tanisha LeGra	and/Daughte		2 East Ro			Salisbury 20c. Location - City of		
Baltimore,			1 X Rurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (sposition (Name of crematory or other Gat Hill Mem	7-28-	2011 I	Hebron, M	ID	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	tioensee S.		22. Name and Address of ennie Smi Funeral Ho	th me Sali	W. Isa	abella St <u>MD 2180</u>	11	
i				r complications that caused only one cause on each line	the death. Do not	enter the mode of dying, s	such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death	
J	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or ma	consequence off.	preuman	ya		·	7	
-	Examiner	<u></u>	Sequentially list conditions,	b. And	eurour	1 0/00	renal	freit	UK		
	ted J unsit	Examiner	cause. Enter Underlying Cause (Cisease or linjury	CH1	The state of the s	will ton	frilux				
	icate be executed physician and s the burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of.	1.1					
760	icate be physic s the b	edical		d. Step	pare	Fai We					
Box 68	that the death certificated by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy			23d. Date of d	elivery Day Year	
	he deat y the at ched fo	hysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 Other (specify)			W.S.M.		
s, P.O.	requires that the death certific been signed by the attending should be detached for use as	by	Part II. Other significant conditi	ons contributing to death b	ut not resulting in th	ne underlying cause given	in Part I.		bacco use contribute t res 2 □ No 3 □ I	to the cause of death? Probably 4 4 Higher	
of Vital Records,	The law requires ate has been sign page 2 should be	Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of	
II Re	sician: The law of certificate has the irector, page 2 s	Be Cor	25. Was case referred to			26. Place	e of Death (Check	1 Yes		es 2 No	
Vita	hysicia his cert I direct	To B	examiner?		ent 2 ER/Outpa	atient 3 DOA Other:	4 Nursing Hor	me 5 🗌 Resid	ence 6 🗌 Other (Spe	ecify)	
n of	Attending Physician: or death. ector. After this certific by the funeral director,	cate:	27. Manner → Death 1	ng 28a. Date of injui (Month, Day		ry work?	t 2 es 2 🗆 No	28d. Describe h	ow injury occurred		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could 4 Homicide deterr	not be 28e Place of Init		street, factory, office	2	28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,	
	o the Hospital or I thin 24 hours after the Funeral Dire	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of ea g Nurse Practioner: To the	xamination and/or in	vestigation, in my opinion,	death occurred at	the time, date ar	nd place, and due to the	e cause(s) and manner stated.	
	To the within To the compl	Σ	only one) 3 Certifying 29b. Signature and title of certified		best of my knowled	29c. License nu			29d. Date signed (Mon		
			1	- FN	pc	R12	6106		7/21/2	roll	
	1		** **			- Duint					
	, E		30. Name and address of person Chris Davis 31. Date filed (Month, Day, Year)			oe, Print) 100 E. Carr	roll st.	Salis	bury, mi	21801	

			_ State	epartment of Health and N Ce <i>rtificate of Death</i>	Mental Hygiene Reg. N	2011 20000
			Registrar 1. Decedent's Name (First, Middle, Last)	Jertificate of Bodiff	2. Date of Death	3. Time of Death
	Physicia	_	James Taylor		Month Da	ay 2011 3:55 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
أب			Horbor Hospital	Baltimore C	ity	N/A
	Funeral		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Days Hours Min.	8. Date of Birth $Ju IV 29^{Year}$	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent		pary 25 i	5 10 117 001011110
	and show	ē	10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Anne Arundel Brook	lyn Park		1 ☐ Yes 2 🏋 No
	h the		10e. Street and Number	10f, Zip Code	10g. C	Citizen of What Country?
	th with ms 2; must	Funeral	4100 Audrey Ave	21225 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - American Indian,
10	or ite	by Fi	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1. Was Decedent Ever in U.S. Armed Forces? 1. ▼Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
030	rs afte Iral", Exar	edk	3 \square Widowed 4 X Divorced If Yes, Give Year or Dates $1964-77$	1 ☐ Yes 2X No Specify:		Specify: Black
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121	thin 7	l S	Elementary/Seconday (0-12)	e. DO NOT use retired) Mechanic	Se	elf Employed
d 2	ed wil Hygie other ent, ti	0 1	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maider	
lan	l be fil fental rked tic ev	ပ္	George R. Shaw	Mary T	aylor	
lary	should and N is ma			Mailing Address (Street and Number or Ru		
Σ,	nd 2 siealth m 27		Selena Byrd(Adopted Daughter)			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		Cemetery.	oisposition (Name of crematory or other place) and Veteran 7-2		Location - City or Town, State DWnsville, Md.
Iţim	it. Pag rtmen rtant njury		T Bonation o E Other (opeony)	Miname a Received Feelit Sor		The state of the s
Ba	perm Depa Impo any i		21. Signature of Funeral Service Licensee	1922 Forest Dr.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	adial Infaction	n	Onset and Death
_	Medical Examiner			andial Infanction		years
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90	requires that the death certificate be executed. been signed by the attending physician and should be detached for use as the burial-transition.	dical	d			
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S,	uires in sigr	ed b	Hypertension, Hyperlipides	mid	1 🗌 Yes	2 No 3 Probably 4 Unknown
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of Vital Records,	The ate pag	Completed			performed?	death? No 1 Yes 2 No
ta	ilcian: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che		
ξ	Attending Physician: ar death. ector: After this certific by the funeral director,	۱	1 Nes 2 □ No 1 □ Inpatient 2 ► EP/Outp 27. Manner of Death 28a. Date of injury 28b. Tir	patient 3 L DOA 4 L Nursing F	lome 5 Residence	
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Division	Attendie er death. ector: A by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
<u>≥</u>	tal or is after al Dir led in					
	To the Hospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner stated.
	To the I within 2 To the I comple	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowle	29c. License number	29d. [Date signed (Month, Day, Year)
	F S F Ö		I Stevenson, MD	D68793	Ju	ly 19 2011
	nal					
	2.46		Karen Stevenson, MD. Harbon Hospits	of, 3001 J. Honover St.,	Baltimore, 1	ND CICCS
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Ty Karen Stevenson; MD, Harbon Hospita 31. Date filed (Month, Day, Year) 2011 32 Registrar's Signature	park		

DHMH 17 Rev 7/2009

11-05158	Please Type	e or Print in Black inc e of Marviand / Depar	delible Ink. Ens	ure All Copies	Are Legi	ible.	25551
Christopher Thigp	en Stat 1- For State	J		and Mental Hy	giene	2011	20001
	Registrar		fificate of Death		Reg	No.	Time of Death
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	4a. Facility Name (if not institution,		4b City Town	, or Location of Death	July 10, 201	4c. County of Death	
	Southbound Ritchie Mar		Upper Ma			Prince George	
Funeral	Social Security Number 6.	Sex 7. Age (In yrs. las	st birthday) If Under 1 \	Year If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Birl	hplace (State or
Director	577-25-0807	XM 2 F		Days Hours Min.	Oct 26	1976 Foreig	n untry)D.C.
	Usual Residence of Decedent	ZE W Z F	0 1 115.				,/
any	10a, State 10b. County	10c. City, 1	Fown or Location				10d. Inside City Limits
*	_MarylandPrince	George's Su	it1and				1 Yes 2 No
Aaryland 28a-f show 1 at once	10e, Street and Number		10f. Zip Cod	e	10g	. Citizen of What Cour	ntry?
1215-0036 de filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	3302 Curtis D	r.	2	20746		USA	
is 23,		12. Was Decedent Ever in U.S		Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ameri	can Indian, Black,
item item	11. Marital Status 1 Never Married 2 XMarri	ed Armed Forces?	If Yes, specify Cu	ban, Mexican, Puerto R	ican, etc.)	White, etc.	
Berd F.		ed If Yes, Give Year or Dates:	1 Yes 2X	No specify:		Specify: B1	ack
t in the same of t	15. Decedent's Education (Specify		16a. Decedent's Usual Occu	pation (Give kind of wo		6b. Kind of Business/I	
22 h 23 h 24 d	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, La	College (1-4 or 5+)	•		۵)	Bates Tr	
Arthin Media	12th	0	Truck Dri			Trucking	Co.
Fied y	17. Father's Name (First, Middle, La	·		18.Mother's Name (F	•	•	
21215-0036 uld be filed within 7 Mental Hygienc. marked other than e event, the Medica	William Thigp				es Joyr		
Should should and Me			19b. Mailing Address (S				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Healin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed Hy European Director.	Sabrina Thigp 20a. Method of Disposition		\$003 Lee Ja			20c. Location - City or	
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr	1 X Burial 2 Cremation		ece လုပ်ခဲ့po မျိုးက မျိုးကုန် ရက် ematory or other place)	i.e.exi		·	
Page ment ment or ot	4 Donation 5 Other Spec	iry.	t. Lebanon	7-23		Adelphi,	
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	Lavy S. Se	ese		rest Dr.			
Physician /M oi al	23a. Part I. Enter the disease, or co failure. List only one cause on		Do not enter the mode of dyl	ng, such as cardiac or r	espiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease	a. Multiple Injuries					Death
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i i	cause. Enter Underlying Cause	С.					
, t	events resulting in death) Last	Due to (or as a consequence of):					
executed an and al-transit		d					
		AMENDED	_				
5. Box 68760, the death certificate be by the attending physical sched for use as the burian Dhyseirian/Madi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna		3 Ectopic pregnanc	TV.	23d. Date of delivery Month D	ay Year
x 687 h certific tending use as th	past 12 months?	4 Pregnant at time of deal	2		,		ay roun
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Division of Vital Records, P.O. hal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach wrifterstion: To Be Commissed by D.	<u> </u>				1 Yes	2 ✓ No 3 Prob	ably 4 Unknown
Records, 1 : The law requires ficate has been sig , page 2 should be					24a. Was an autopsy		opsy findings available empletion of cause of
eco ne law te has					perform 1 ✓ Yes 2	ed? death?	_
tal Rection The certificate ector, page		T .	26.Pl	ace of Death (Check on			2 110
Vital yrician his certi	examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient 3 DOA	Other4 Nursing	Home 5 Re	esidence 6 🗸 Other	Scene
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on auth. he fu	1 Natural 5 Pending		1919 hrs 1	Yes 2 V No	perator of m	otorcycle that str	uck a fixed object
Visior or Attend fler death Director: in by the	2 🗹 Accident Investig	28e Place of Injury - At hor	ne, farm, street, factory, offic	e building, etc. 2		eet and Number or Rui	al Route Number, City
Division o oppital or Attending hours after death. Insert Director: After filled in by the fune Contification:	4 Homicide determine		/ Highway	Sc	or Town, Stat outhbound Rite	e) chie Marlboro Road	Upper Marlboro, MD
		Ician: To the best of my knowledge	e, death occurred at the time	, date and place, and du	ue to the cause(s) and manner as state	d.
To the Howithin 24 h To the Fun completely	one) 2 Medical Examin	ner: On the basis of examination and and manner stated.	d/or investigation, in my opin	ion, death occurred at t	he time, date an	d place, and due to the	cause(s)
H N F N	29b. Signature and title of certifier		29c. Lice	ense number	2	9d. Date signed (Mor	th, Day, Year)
	Donnel Krush	ull nas	0.0	C.M.E.	,	July 11, 2011	
, į	30. Name and address of person wt	o completed cause of death (Item 2	(3a)				
4	Pamela E. Southall, MD			ore Street, Baltim	ore, MD 212	23	
Stat	e 31. Date filed (Month, Day, Year 6	32. Registrar's Signature	4 4				
Registra		Claus ,	B. parks			00115	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 6:45A M Totaro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2866 Portobella Court Charles Waldorf If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Pay, Year)
| January 11, 1930 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months 578-36-4494 Washington DC 81 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 2866 Portobello Court 20603 USA than "natural", or items 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Angelo B. Totaro Anna G. Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10234 Spring Hill Newtown Rd. La Plata, MD Rick Williams/Great Nephew 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brinsfield-Echols Crem. 7/23/2011 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00945 2A Pane and Address of Facility Funeral Home, P.A. (acre St Mary's Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent a the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? the Hospital or Attending Physician: The law this certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 🗓 No 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA apleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred After t Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending death. Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the only one Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29 c. License number 29d. Date signed (Month, Day, Year)

3 D.C.

State Registrar

DHMH 17 Rev 7/2009

Rober

live center

302

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 018

3. Registrar's Signature

July 22, 2011

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician/ 201 A^{M} 8:30 Leon Alford Taylor Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 **X** M 2 □ F Hours (Manth, Pay, Year) 32 245-60-9210 78 North Carolina Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location death with the Maryland ar than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tes 2 X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29991 Hickory Drive 20659 U S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?
X Yes 2 \sum No Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or any injury or other traumatic avent the "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Battery Dist. Automotive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ္ဂ Sally Mae Sessoms Ira M. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian G. Taylor/Spouse P.O. Box 363, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem.Gardens 08/02/2011 Waldorf, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signa re of Funeral Service Licens -MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ MOLANO o Carcinum disease or condition Medical resulting in death) Due to (or as a conseque of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Other (specify) the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? | ≥ ☑ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No certificate 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: Certificate: To I 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29/11 65277

State Registrar 31. Date filed (Month, Day, Year, AUG

Mcdic. 32. Registrar's Signature

7003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 210 Annions Mo 21401

		-	State of Maryla State Registrar		rtment of F tificate of D			giene Reg. N 2011	25557		
			Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year 3. Time of Death				
	Physicia Medic		Joan Teresa Turner				July	30, 2011	5:10 A M		
	Examin		4a. Facility Name (if not institution, give street and number) 37681 Asher Road			Location of Death		4c. County of Death St. Mary's			
	Funeral Director		5. Social Security Number 579–46–5831 6. Sex 1 □ M 2 7. Age (in yrs.) 75	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 3	9. Bir Year 1936 Was	thplace (State or Foreign puntry) hington, DC		
		'n	Usual Residence of Decedent 10a. State 10b. County 10c. County	City, Town or Loc	cation				10d. Inside City Limits		
	/laryla 8a-f s tified	Director	Maryland St. Mary's M	echanic	sville				1 🗌 Yes 2 🔀 No		
	a or 2 be no		10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?		
	th with ms 23 must	Funeral	37681 Asher Road	16 13 1	206. Vas Decedent of Hi		ecify Ves or No-	USA 14. Race - Ame	orican Indian		
336	e filed within 72 hours after death with the Maryland tall Hyglene. ad blyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 🕷 Widowed 4 □ Divorced 12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 🕷 No If Yes, Give Year or Dates.	l1	Yes, specify Cuba	n, Mexican, Puerto		Black, Whit			
2-0	hours natur dical	olete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	ation	sina	16b. Kind of Business	Industry		
21215-0036	led within 72 Hygiene. other than ' ent, the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired) Owner			Retail Ce	ramics		
Maryland 2	be filed v ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Francis Clemens Brahler			18. Mother's Nan	er's Name (First, Middle, Maiden Surname)				
aryl	2 should be file th and Mental 27 is marked of traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ig Address (Street	and Number or Rui	al Route Number	; City or Town, State, Z	ip Code)		
Σ	and 2 sl Health a tem 27 i		John F. Brahler - Son	229	90 Holl	ywood Roa	d Leon	ardtown, M			
Baltimore,	101		1 X Burial 2 Cremation 3 Removal from State		sition (Name of natory or other place aven Cemet		Date 03/2011	20c. Location - City o			
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	22	Name and Addre Matting I P.O. Box	ey-Gardi 270 Lec	ner Fune nardtow	ral Home, l	P. A.		
-	Medical Examiner	iner	23a. Parl 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter uncorrying Cause (Disease or injury)	g Car Juence of):	cer	g, such as cardiac	est,	Approximate Interval Between Onset and Death MON HAS			
_	ate be executed ohysician and the burial-transit	dical Examine	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a conse	equence of):					Le gairs		
760	cate by phys	ledic	d								
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month			
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Division of Vital Records,	The law require ate has been si page 2 should	Completed by					24a. Was autor perfo	osv prior to	autopsy findings available completion of cause of less 2 \(\text{No} \)		
alF	ician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?		26. P	lace of Death (Che					
Σ	Physic this ce al dire	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatie		4 L Nursing F		dence 6 Other (Spe	ecify)		
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ivisio	Il or Attendi after death Director: A d in by the fi	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office			n (Street and Number or Rural Route Number, Town, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my kni (Check only one) 3 Certifying Nurse Practioner: To the best of	tion and/or inves	tigation, in my opini	on, death occurred	at the time, date a	and place, and due to the	e cause(s) and manner stated.		
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,											
			Monife fleer	26)		004784	7	8.1.	2011		
191	b		30. Name and eddress of person who combleted cause of death (If Monika G-Lee, MD 2			reet Leo	nardtown	, Maryland	20650		
	Sta Registr			nature .	back						

DHMH 17 Rev 7/2009

		4	For State	State of Maryland				/lental Hyg	giene	1 25558)
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of Dea	Reg. No. U	3. Time of Death	_
	Physicia							Month	Day	Year 8:30 AM ^M	
	Medic		Linda June Valen 4a. Facility Name (if not institution, give stre			4b. City, Town, or	Location of Death	August	4c. County o		\dashv
أريب	Examin	er	21737 Pinehurst C			Leonar				Mary's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birthplace (State or Foreign	7
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	ld now at	l 1	Usual Residence of Decedent 10a, State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits	\exists
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	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ᇤ	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp.		- American Indian, White, etc.		
36	after (b	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1	☐ Yes 2 X No	Specify:		Specify:	White	
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yla	should be file h and Mental I 7 is marked o traumatic eve	잍	Clarence Jobson					y Greer			\dashv
Nar	shou h and 7 is m traum		19a. Informant's Name/Relationship (Type,	Print)	ı	g Address (Street a					
e,	and 2 Healt em 2		Mark Hays / Son 20a. Method of Disposition	20b. Pla		7 Pinehur sition (Name of	St CL.,	Date		Dity or Town, State	_
nor	age 1 ant of t: If it		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ce	metery, cren	natory or other plac Cemetery		2011	Waterto	wn, New York	
Baltimore, Maryland 21215-0036	artme ortan injur	Home, P.A.									
ñ	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		Edward N. Brinsi	ield, Jr. MO		2955 Holl					
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between	
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Second .	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
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9	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dical	d.								
	ificate ng phi as th	Med	IF FEMALE:								
Box 687	eath certificat attending ph d for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan 1 Live Birth 2 Fetal	death 3	Ectopic pregnanc	у		23d. Date Mon	e of delivery th Day Year	
	deat the at hed fo	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5∟	Other (specify)					
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of Vital Records,	requ been shoul	Completed						24a. Was		ere autopsy findings available	Э
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al H	ician: The certificate rector, pag	Be C	25. Was case referred to medical			26. PI	ace of Death (Chec		2 12 110		
Zi:	nysici lis cer direc	TO B	examiner? 1 Yes 2 No	spital: 1	ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	ome 5 X Resi	dence 6 🗆 Othe	(Specify)	
of	ng Ph fter th Ineral	ige:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	?	28d. Describe I	now injury occurre	d	
ion	tendii leath. tor: A the fu	ific	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 ☐ No	000 1 1 1 1	Character of Normalia	r or Rural Route Number,	_
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Ω	spital	ical	29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	edge, death	occured at the time	, date and place, a	nd due to the ca	use(s) and manne	r as stated.	
	ne Ho nn 24 I ne Fur	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of examination Practioner: To the best of my	and/or inves knowledge,	tigation, in my opinion death occurred at the	on, death occurred e time, date and pla	at the time, date a ace, and due to the	and place, and due ne cause(s) and mar	to the cause(s) and manner sta nner as stated.	itea.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, page 1888.		29b. Signature and title of certifier	nno		29c. Licenson	e number 17597		29d. Date signed \$-2-	(Month, Day, Year)	
	12A		30. Name and address of person who cor			Print)		1 .	- MD 001	50	
	Sta	te.	Jefferey Brown, M 31. Date filed (Month, Day, Year)	32. R gistrar's Signat	ure ,	Lookout	koad Leo	naratowi	1, MD 206))U	~
	Registr		AUG 5 20	11 Sener		back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No-. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1:35 6 W AZZZUAU 2000 WACKER-STUART 55- 5011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Aruno Burnic Anne Glen Medica **Funeral** 1 □ M 2 **X** F Months Days Hours Min. Oct 1988 Maryland 22 218-21-9788 **Director** Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 2136 Mulberry Hill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married þ Valker-Stuart, Vanessa. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Black Completed 3 Widowed 4 Divorced or other traumatic event, the Medical 16b. Kind of Business Industry Bayada Home Care 15. Decedent's Education 16a. Decedent's Usual Occupation (Giverlying of working life, bond Tuse remain) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Specialist 12th 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Valerie Stuart Randy Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 3929 Cedar Dale Rd. Baltimore, Md. 21215 Valerie Stuart(Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Metro Crematory 8 - 1 - 11Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Winname a Reder seof Facility Sons Mortuary, 1922 Forest Dr. Annapolis, 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2 DMC PARAGONOUS EMBOU Medical Due to (or as a consequence of **Examiner** POULUGARY IMEEK Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir the burial-transit and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 X Yes 2 No
9 Unknown Day Month Pregnant at time of death signed by the a 14,2011 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SAH (post-tPA) 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? Yes 2 No 1 ☐ Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes ြု 1 Na Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

5́ω State

State Registrar 1. Date filed (Month, Day, Year)

32. Reaffistrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chiconus Jos Crangeour

JUL 26 2011

Registrar's Signature

D0065711

JUCA 55 35011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day Physician/ 1057AM lan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours July 31 Year 944 Virginia 217-58-4308 66 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 1 Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10g. Citizen of What Country? Funeral 21035 USA 1751 Governors Bridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 8th College (1-4 or 5+) Laundry Worker Ginger Cove Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Steven J Willis Ruth V Bower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21035\,$ 19a. Informant's Name/Relationship (Type, Print) Joseph H. Wilson(Husband) 1751 Governors Bridge Rd. Davidsonville, Md. 20a. Method of Disposition 2014 Place of DSpesition (Hame of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-26-11 Annapolis, Md. Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Mane a Romers con Facility Sons Mortuary, P.A. Lavy S. K 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ abotes disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Ho Month Day 5 Other (specify) Pregnant at time of death _ Yes 2**.** □ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of perlipidem. 24a. Was an the Hospital or Attending Physician; The law cate has I autopsy performed Yes 2 death?
1 Yes 2 No After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes မ R/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending iniury 24 hours at er death. Funeral Director Af Investigation 3 Suicide
4 Homicide 6 ☐ Could not be within 24 hours at er dear To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical A certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) m y

State

Registrar

Darks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

31. Date filed (Month, Day, Year) JUL 2 6 2011

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type o											ible.		
	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. N. 20 2556																
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Funeral		5. Social Security N		6. Sex 1 ☐ M 2 🕱 F		ge (In yrs. la	ast <i>birthda</i> Yrs	Mont	hs Days	If Und Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D Nov 2	rth ay, Year)	10	Cot	hplace (State or Fo untry)	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 21. Signaturerof Fu				For	t Li		Ceme			//11 rt L i nc		entwo			
permi Depar Impor any ir		21. Signature of Fu	AM	LCLS.								d Bren				20722	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1	Certifyin	g Physician: To th	e best o	f my know examinatio	rledge, de	ath occure	d at the tim	e, date ai	nd place, a	nd due to the c	ause(s)	and manr	ner as sta	ated. cause(s) and mann	er stated
the L	₩ We	only one) 3	3 Certifyin	g Nurse Praction	er: To the	e best of m	y knowled	ge, death o	29c. Licens	he time, c	date and pla	ice, and due to	the cause	e(s) and m	anner as	stated.	
5 ¥ 6 8		29b. Signature and	title of certifie	her							20	(29a. L	711	27	h, Day, Year)	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)																
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State Registrar		Otate of W	ai yiai k			of Deat			Reg. N2	011	25562	
Physicia		1. Decedent's Name (Fin		hh						2. Date of De Month July 24	ath		3. Time of Death 12:01P M	
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items	Funeral	11. Marital Status	12	2. Was Decedent I Armed Forces?		13. V			c Origin? (Spe	ecify Yes or No- Rican, etc.)	.	4. Race - Am Black, Whi		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Q7 Physician/ 6:05 WILLIARD SR. 2011 DONALD Medical 4b Arty, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** lisburu COMECO tospice 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** (Month, Day, ^{Year)} 1922 Months Days Hours PENNSYLVANIA 88 Director 180-18**-**3055 AÙG. Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 No WILLARDS MARYLAND WICOMICO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Examiner must be USA 21874 Funeral 23a 9104 BETHEL ROAD 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 9 and 2 should be filed within 72 hours after Maryland 21215-0036 WHITE 1 ☐ Yes 2 🔀 No Specify: "natural" 3 XWidowed 4 ☐ Divorced Completed Year or Dates.1943-45 the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) RELIGION PASTOR Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARGURITE DECK HOWARD WILLIARD SR. Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 34470 WORKMAN RD., PITTSVILLE, MD 21850 FRANK W. ANDERSON III/EXECUTOR Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State SPRINGHILL MEMORY HEBRON, MARYLAND 7/26/11 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Fineral Service Lice HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part 1. Enter the disease, or complications that carbod the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LGNAN disease or condition Medical resulting in death) Examiner Sequentially list conditions, Dualto (or sella considuente of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last nding physician Medical Box 68760 the ! use as 1 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months? Month Day ρ 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 1 ☐ Yes ∠ □ 9 ☐ Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion death? page 2 s autopsy performe 1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 **N**0 ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After Natural 5 Pending iniury ☐ Accident Investigation filled in by the Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
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State Registrar TAN SASTE DE, SAUSBURY

and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signatu

Earl Warwick 7/21/11 11:55pm

		1	For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment of F tificate of	lealth a Death		Reg. N			25564
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Mary.	/Medic Examin	al -	tall G. Walking Ha. Facility Name (If not institution, g.				4b. City, Town, o	r Location o	f Death		1c. County of	Death	1-
			ManokinM	anor			Prince If Under 1 Year	PSS	Inne	of Birth	_ / _ /	ev.	SeT ace (State or Foreign
	Funeral Director		5. Social Security Number 6. 218-01-2352	<u></u>	e (In yrs. I 96	as <i>t birthday)</i> Yrs.	Months Days	Hours	Min. Dec	of Birth th, Day Yea	1914	Som	erset
		- H	Usual Residence of Decedent		10- 04	y, Town or Lo	action					10	Od. Inside City Limits
	show	_	Md. Somerse	+		incess							1▼Yes 2□No
	the Nr 28a-f	irect	10e. Street and Number				10f, Zip Code				Citizen of Wh		
	th with use 23a o	ralD	30431 Pine Stre				218				14. Race		
336	flied within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, it of Notical Examiner must be notified at	by Fui	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 □Yes 2★No	an, Mexican	gin? (Specify Yes i, Puerto Rican, et	or No-		White, 6	etc.
2-0	72 hou natura iical E	eted	15. Decedent's (Specify only highest g	Education grade completed)		(Give	dent's Usual Occu kind of work done	during most	t of working		. Kind of Busi		urniture,
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retire	•					Stores
102	il Hygi other ent, II	a)	17. Father's Name (First, Middle, La.						er's Name (First, I				
ylar	should be nd Mental marked o	To B	Joseph Warwi	.ck					rtrude W			toto Zir	Cadal
Maryland 21215-0036	d 2 sho th and 7 Ism traum		19a. Informant's Name/Relationship Elizabeth Warwic				ng Address <i>(Stree</i> L Pine St					2185	
ē,	s 1 and Heal if Heal item 2		20a. Method of Disposition		20b. F		osition (Name of matory or other pla	ice)	Date	20c	. Location - C		
Baltimore,	Pages ment of I ant: If ite		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			echwo	od Cemete	ry	07-26-20				Anne, Md.
Balt	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "ne any injury or other traumatic event, If a I wate.		21. Signature of Funeral Service Lic	ensee	M002	105	2. Name and Addr 1673 Some				eral H		1. 21853
	22209		23a. Port. Enter the disease, or co	emplications that cause	d the deat							, 110	Approximate Interval Between
-	Physician	a 1	ock, or heart failure. List on Importate Cause (Final disease or condition	ly one cause on each i	ne.	A	SCUD						Onset and Death
	/Medical Examiner	3	resulting in death)	Due to (or as	a conseq	juence of):							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consec	quence of):						-	
	ate be executed hysician and the burial-transit	Examiner	that initiated events	C								-	
760,	be exe ician ai ourial-t	EX	resulting in death) Last	Due to (or as	a conseq	luence of):							
687	ficate y physi s the k	edical		d									
O. Box	Attending Physician: The law requires that the death certificate be executed refeath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗆 Feta	al death 3	☐ Ectopic pregnar ☐ Other <i>(specify)</i>			23d. Date of delivery Month Day Year			
ords, P.	equires that the death	þ	Part II. Other significant condition	s contributing to death	ing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown			
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been scompletely filled in by the funeral director, page 2 should	Completed							1[d2 B	Vere aut rior to c eath? □Yes	opsy findings available ompletion of cause of
Vita	sician certifi irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2	T EB/Outnatio	ent 3 DOA	Almore	e of Death (Chec		ce 6 □Othe	er (Spec	eify)
ot	g Phy ter this neral di	Certification: To	27. Manner of Death	28a. Date of In (Month, D		28b. Time	of 28c. In				injury occurre		
sior	eath. or: Aff	catio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion				□Yes 2□		nation (Ctro	at and Numb	er or Ru	ral Route Number,
ivi i	or Att after d Direct in by	ırtifi	4 Homicide determin	200, Flace Ul II	ijury - At r etc. <i>(Sp</i> ec	ify)	treet, factory, office	9	Cit	y or Town, S	State)	5) () 110	a Houte Humber,
_	Hospita 24 hours Funeral	Medical Co	29a, Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	t of my kn of examin stated.	nowledge, dea	ath occurred at the investigation, in m	time, date a	and place, and du eath occurred at the	e to the cau ne time, date	use(s) and ma e and place, a	and due	stated, to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c. Lice	nse number		290	i. Date signed	d (Month	n, Day, Year)
	JA.		P 24/3	he completed	donth /It-	m 22a) (Time	Print)	70°	77		7/2	211	1
	Turl		30. Name and address of person w	47234-V	death (ite	415	5. DIVI	510V	sheer	SAL	15 BU/	ry	M) 21804
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 2	Physician: 10 the best xaminer: On the basis and manner such completed cause of 32. Regis	trar's Sigr	nature .	pare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 25565 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20^{a_y} 20^{Yea}1 Katherine Lucille Young 1:15p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sunrise Assisted Living Frederick Frederick Date of bill (Month, Day, Ye Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min **Director** 193-16-4251 91 Ohio 1920 March Usual Residence of Decedent shov 10a. State at 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be r Funeral 990 Waterford Drive 21702 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No "natural", or i Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Nidowed 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Cuzic Alice Harrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Alice Hilderbrand/ Daughter 11913 Lynn Crest Road, Monrovia, Maryland 21770 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, Virginia Sign were of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, MD 21702 Pamille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final enebral Vascylan Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last lementi Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No Pregnant at time of death
Unknown signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 1940 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical director. Be 26. Place of Death (Check only one) 1 🗌 Yes Other 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death. Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical

within 24 ho

To the Fune

completed fi AD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

29a. Certifier

(Check

3

29b. Signature and title of certifit

Martha Pierce, M.D.

300 West 9th Street, Frederick, Maryland

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 46248

29d Date signed (Month, Day, Year) 12811

21701

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 1, per phy, g918 8-11-11 sm State of Maryland / Department of Health and Mental Hygiens 0 1 1 25566 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Mamie Ruth Andrews 2. Date of Death Physician/ Month M 1105 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** County of Death ESSEX Kogo timore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Hours Min. Country) 1 M 2 F Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ESSEX 21205 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married þ filed within 72 hours after 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ₩idowed 4 Divorced "natural", Completed lac other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 2 Page 1 and 2 should 19a. Informant' ame/Relationsh p (Type, or Town, State, Zip Code) ldavs Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service bicens 22. Name and Address of Facili Funcial Services Van chr MD21133 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2003 Medical resulting in death) Due to (or as a conse lence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the ! attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 🗆 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours a Medical 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Number Transference To the coast of my knowledge coast occurred at the time, date and place, and due to the name as interior. (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) ust & 2011 D0022213 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Stol Lock Raven Blod. Baltimore, no 21239 Paral J. Walman 32. Reportrar's State Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 05 M 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** GENERA AWOH MBI 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country) 1 🗆 M 2 🕱 F 0870171927 NJ 135-22-7985 84 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland notified at Director 1 🗌 Yes 2 🗓 No 28a-f COLUMBIA MD HOWARD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or Funeral with 1 21044 USA 5495 GREEN DORY LANE permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medical Examiner mus once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL TECHNICIAN MEDICAL 1+ Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ RHEINGOLD HALPRIN **EMANUET** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5495 GREEN DORY LANE, COLUMBIA, MD 21044 LOUIS AMSTER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State COLUMBIA MEMORIAL PARK 08/10/2011 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart felline. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 Sequentially list conditions. Examine cause. Enter Underlying -transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) the burial physician Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant
9 Unknown Pregnant at time of death been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has lirector, page 2 s 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 5 Pending 1 Natural 1 🗌 Yes 2 🗀 No n 24 hours after death.

e Funeral Director: A sleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 64539

DHMH 17 Rev 7/2009

State Registrar 55 CEDAR LANE,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUMURU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14945 Medical Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Genera 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ✓ M 2 □ F (Month, Day, 8 Months Days Hours Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 stroutu by many permit. Page 1 and 2 stroutu by Bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ø 19a. Informant's Name/Relationship (Type, Print) Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD 21. Signature of Fune I Service Licensee eral Hor Name and Address 0 dised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. Enter the diseas or complications that 23a, Part 1 Approximate shock, or heart failure Interval Between Immediate Cause (Final Onset and Death Pnysiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be a 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 V No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Hospital: Other: မ ER/Outpatient 3 DOA 1 Nnpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man er of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes Natural 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier House stabl Vunnam. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32: Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

AUG 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar 25569 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner Eacility Name (if not in stitution, give street and number 4b. City, Town, or Location of Death 4c. County of Death more If Unde **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **™**M 2 □ F Months (Month, Day **Director** 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Nes 2 No 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print Daug hter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 20a. Method of Disposition Place of Disposition (Name of Date 20c. Logation - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodla Woodlawn Home, P.A. MD 21216 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. L Immediate Cause (Final Physician NEUM disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner U) 20 Sequentially list conditions, if any leading immediate cause. Enter Underlying Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ONIGITIV and use as the burial-tran Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ this certificate has been signial director, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. No Other ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign ture and title of ည 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brown Sr. Month George 11:30 PM August 2011 Medical Facility Name (if not institution, give street and number) Examiner County of Death 3 nda DO. Age (In yrs. last birthday) 24 Hrs. Min. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 2 ∏ F Months Hours Director hington DC 28a-f shov death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. 10g. Citizen of What Country? Funeral 12. Was Decement Ever in U.S Armed Forces? / 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 ₩Widowed 4 □ Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College 41-4 or 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/ \ lationship (Type, Print D : nter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,$ $\,$ $\,$ $\,$ $\,$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau 20a. Method of Dispos 20b. Place of Disposition (Name of 20c. Location - City of Town, State Date 1 🗌 Burial 2 🗷 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) saltimore 21. Signatu 22 Name and Address of Pacility f Fyneral Service Licensee Funeral Home, P. A. 21216 orth Part / Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Atheroscierotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to (6) as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: detached f r use 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 No Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) P 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No Accident Investigation the 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the P only one 29b. Signature and title of certifier NS RajnpalmeM.D 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203 Baltimore 21209

Registrar DHMH 17 Rev 7/2009 2835 Smin

S. Rajapaksc, M.D

1 AUG

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Examiner Baltimore County Season Hospice @ Northwest Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 🗆 M 2 🗶 F Months Hours Min Jan 21 1930 New York Yrs **Director** 81 127-14-1523 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** items 23a or 28a-f s er must be notified 1 🗆 Yes 2 🙀 No Maryland Gwynn Oak Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? death with 21207 United States 2 Walden Holly Court Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Was Decedent Lvo Armed Forces? 1 ☐ Yes 2 **X** No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: BLACK "natural" 3 Widowed 4 Divorced er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other ther er traumatic event, the 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grace Russell James A. Crump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2 Walden Holly Court, Gwynn Oak Maryland 21207 Leon M Berry - Husband Department of Health Important: If item 27 any injury or other to once. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 08-09-2011 Baltimore Maryland Metro Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Balto, MD 21228 Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRA Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Day 5 Other (specify) Month Year Pregnant at time of death signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate Yes 2 Yes 25. Was case referred to dica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence ည ER/Outpatient 3 DOA 1 Inpatient 2 funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury L Natural n 24 hours after death e Funeral Director: ≠ bleted filled in by the f Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 Homicide determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License number who completed cause of death (Item 23a) (Type, Print Registra 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

ngelo Barnabe,		State 1- For State Registrar	ate of Maryland		artment of		and N	/lental Hy		20 Reg. No.	11 25572	
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle	e,Last) rnabae III		-				2. Date of De Month August 4	ath Day Yea	3. Time of Death 0757 hrs	
)		4a. Facility Name (if not institution 1630 Braddish Avenue	n, give street and number			4b. City, Town, Baltimore		ation of Death	<u> </u>	4c. County o	of Death N/A	
Funeral Director		5. Social Security Number 266-71-2290	6. Sex 7. A	ige (In yrs. I	ast birthday) Yrs			Under 24Hrs. Hours Min.	1	irth(MM/DD/YYYY 9/1960	9. Birthplace (State or Foreign Country) Maryland	
nd show any occ.	2	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	10c. City,	, Town or Locat		Ltim	ore Cit	ty		10d. Inside City Limits 1 X Yes 2 No	
the Maryland to 28a-f show		10e. Street and Number 1630 Braddis	h Avenue			10f. Zip Code	е	216		10g. Citizen of Wh	-	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 Never Married 2 Ma	12. Was Deceder									
, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mental Hygiene. ten 27 is marked other than "natural", fraumatic event, the Medical Examiner	Be Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	Lor Dates: cify only highest grade co College (1-4 or		during m	t's Usual Occu ost of working	pation (life. DO	Give kind of w NOT use retire		siness/Industry		
21215-0036 uld be filed within 7 Mental Hygiene 1 marked other than c event, the Medica		17. Father's Name (First, Middle, Angelo Barnal	· ·		<u>N</u>	ever Wo	18.M			Disabled st, Middle, Maiden Surname) Kuhn		
, MD 21 and 2 should ealth and Mer em 27 is man		19a. Informant's Name/Relationsh Angelo Barnabac 20a. Method of Disposition				illside	e Rd	., Cato		e, Maryl	n, State, Zip Code) and 21228 City or Town, State	
Baltimore, permit. Pages 1 at Department of Hee Important: If lie injury or other tr		1 Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:	State Me1	crematory or other creations are created as the cre	matory	Inc	. 08/0	08/2011	Baltimo	ore, Maryland of Maryland	
Balt Bernit. Depart Import	- 1	23a. Part I. Enter the disease, or failure. List only one cause	Hon		29	9 Frede	ericl	k Road.	Balti	more. Ma	aryland 21228 Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. by Hypert Due to (or as a cons								Death	
ted Insit	Examiner											
	edical	X UNPENDED	AMENDED 23a			a-f,pe	r me	,g919	9-12-1	1		
Box 6876C e death certificate the attending physed for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unki	I I CIVE DIIII	ome of pregi	2 Fe	tal death ner (S <i>pecify</i>)	3E	ctopic pregnar	ncy	23d. Date of Month	delivery Day Year	
ires that the signed by the detache	≥	Part II. Other significant conditions Psychiatric I		ith but not re	esulting in the u	nderlying caus	se given	in Part I.			bute to the cause of death? Probably 4 Unknown	
tal Records, P.O.	Completed								1 🗸 Yes	psy p ormed? d	Vere autopsy findings available nor to completion of cause of eath? Yes 2 No	
1 of Vital ling Physician: After this certifuncal director	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	Hospital: 1 Inpati	Year)	ER/Outpatient 28b. Time of In	3 DOA	Othe	Work?	Home 5	how injury occurre		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification	2 X Accident Invest 3 Suicide 6 Could 4 Homicide	tigation Id 8-4	Injury - At ho	fd 7:4 ome, farm, stree idence) am		ng, etc.	tempera 28f. Location (ature (Street and Number (State) 1630	erorRuralRouteNumber,City Braddish Ave.	
To the Ho within 24 h To the Fu	ल		nysician: To the best of n niner:On the basis of exa and manner stated	amination a								
		29b. Signature and title of certifier	Brassell.	MD		29c. Lice O.(onse nur C.M.E			29d, Date signe August 5, 2	ed (Month, Day, Year) 011	
		30. Name and address of person Melissa Brassell, MD	who completed cause of Assistant Medica		ner 900 W		Stree	et, Baltimor	e, M D 212	23		
Sta Registr	te ar	31. Date filed (Month Pay Year)		ar's Signatu	ire b. A	ale						

Please Type or Print in Black Indelible in 12 Engure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 20 2011 July 2:30 PM Margaret Jane Burton 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci1 North East 135 Jethro Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days Hours Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) 1 □ M 2 🛛 F May 8, North Carolina 68 215-42-6337 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2X No Cecil. North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21901 135 Jethro St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 X No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) healthcare registered nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Virginia Goble Elihu Gwyn Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 135 Jethro St; North East, Maryland 21901 Jeff Burton - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Euneral Service Licensee Ronal d S Wade 655 W. Baltimore St; Baltimore, MD 21201 m. 23a. Pirt1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Unknown. Unknown Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1**X** Yes 2√√√ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

Physician /Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed and División of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Be Completed

Certification: To

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Physician

/Medical

Examiner

10a State

MD

Director

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm "Match Evanting that be not expected.

Baltimore, Maryland 21215-0036

the burial-tran physiclan attending pl detached signed by I funeral director, page 2 should this

IF FEMALE 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 8.5.2011.

who completed cause of death (Item 23a) (Type, Print)

ST, Election MD 21921. 126 A, E tligh MD

State Registrar

24 hours after deat Funeral Director:

within 2

filled in by

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #9 Per INF G918 8/19/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1311 ANGUST Physician/ Adam Darrell Burch Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death Examiner 4c. County of Death Baltimore naryland HUSPITAL General If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 1986 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Months Days Hours Min. an 30, Page 1985 Maryland Director 214-11-1349 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21217 1701 Eutaw Place #1001 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Specify: black þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) airport 12 environmental services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Naomi Capers Michael Anthony Burch injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Druid Park Lake Dr; Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) Naomi Capers - mother 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 N Other (Specify) 21. Signature Ronald S. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final prone rane Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consecuence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 2 🗆 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes Be B 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural s after dea. al Director; Aftr 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu

Registrar
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State

31. Date filed (Month, Day,

naryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 09 2011 Year 4:28 PM M Phyllis Elaine Ter Borg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 724 Bowleys Quarters Road If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours Months 0370971928 83 Michigan 366-26-7951 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 724 Bowleys Quarters Road 21220 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 1102/6 Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leta Budd Loel Muston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Bowleys Quarters Road, Baltimore, Md. 21220 John Herman Ter Borg (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 08/15/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. Signature of Funeral Service Lisensed 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shook, or heart failure. List only one cause on each line. Immediate Cause (Final di se or condition resulting in death) OLUN Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Year 5 Other (specify) 9 Unknown the Hospital or Attending Physician: The law requires that the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an is certificate has be director, page 2 s autopsy perfor 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work? 1 🗌 Yes 2 🗍 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 124 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title 🆪 of death (Item 23a) (Type, Print)

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25576 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Aug Day Year Physician/ Μ. Barth Ida 11:00 PM 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** N/A Baltimore City FutureCare Canton Harbor If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 11, 1917 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** Months Hours Maryland 214-14-4380 Director Usual Residence of Decedent or 28a-f show notified at 10d, Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Dundalk 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 rral", or items 23a or Examiner must be r Funeral United States 943 Elton Avenue 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc. er than "natural", or i by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Two Guys Stores Retail Clerk 6 Years Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Matilda Hinckle ပ္ Edward Eckelt 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 142 Kathy's Lane Hedgesville, WV 25427 19a. Informant's Name/Relationship (Type, Print) Warren W. Barth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland Gardens of Faith Cem. 8/15/2011 4 Donation 5 Other (Specify) Bulda-Rick Puneral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, Maryland 23 Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart factor. List only one cause on each line. Interval Between Arterio schadie Cornay Viscobed seare Onset and Death Immediate Cause (Final Dillo (or as a consequence of): Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confirmation to the Funeral Director: After this confirmation. and I-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant a 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ whitenown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? busit caused autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 횬 2 LH0 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 Yes 2 No iniury 1 Natural 5 \square Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 01966 -10-2011

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Glen Riene, Hayland 2106 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		For State Registrar	State of Maryla		tment of the ficate of L		Mental Hy	Reg. No. 20	11 25577
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Examir	ner	4a. Facility Name (if not institution,			Balto	110		4c. County of	of Death
Funeral Director		220-24-5405	6. Sex 1 □xm 2 □ F 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Aug • 2	rth ay, Year) 26,1928	9. Birthplace (State or Foreign Country) Maryland
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD 1 10e. Street and Number	Baltimore 10c.	City, Town or Loca	tion	Ec	lgemere	10 00	10d. Inside City Limits 1 Yes 2 No
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1036 rs after deatl ural", or item		11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	If Yes, Give		s Decedent of H res, specify Cuba ☐ Yes 2 🙀 No	lispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- American Indian, K, White, etc. White
Baltimore, Maryland 21215-0036 sernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho mynjury or other traumatic event, the Medical Examiner must be notified at page.	Completed by	15. Deceden (Specify only higher Elementary/Seconday (0-12) 6 Years	t's Education st grade completed) College (1-4 or 5+)	(Give kin life, DO	nt's Usual Occup d of work done o NOT use retired) pe Mill	during most of woi	rking	16b. Kind of Bu	siness Industry Industry
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Mary 2 should h and M 7 is ma traumat		19a. Informant's Name/Relationsh Mr. Harold W.						er, City or Town, St	
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Balti permit. Departin Imports any inju		C Magon	Elan	Dud	ia-Ruck 22 Wise	ss of Facility Funeral Ave. Du	Home ^o ndalk, l	f Dundall Maryland	k, Inc. 21222
nysician/ Medical		23a. Part 1. Enter the disease, or shock, or hear dailure. List or immediate Cause (Final disease or condition resulting in death)	complications that caused the de- nly one cause on each line. EUKEM Due to (or as a conse	14	he mode of dyin	g, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.		3 Suicide 6 Could n 4 Homicide determin			, factory, office		28f. Location (City or To		r or Rural Route Number,
ne Hospi n 24 hou ne Funer	Medical	(Check 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examinat Nurse Practioner: To the best of	tion and/or investiga	ation, in my opinio	on, death occurred	at the time, date	and place, and due	to the cause(s) and manner states
To the within common		29b. Signature and title of certifier	0,		29c. License			A	(Month, Day, Year)
		30. Name and address of person w	the completed cause of death (Ite	em 23a) (Type, Prin Hにんかに	it)	8560 RD #2	DB /	200-50	1 8, 2011 15, MI)
Sta		31. Date filed (Month, Day, Year)	7EMAC 9106,		YHIA	トツベト	- 0 1	-ULE MAL	-6,179
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 2<u>011</u> Month Physician/ 1:15 P.M August 9 William Roy Benway Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Timonium 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** OCt 4, 1 XM 2 D F 1933 Kentucky Director 281-30-1078 77 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛂 No Fallston Maryland Harford 10f. Zip Code 10a, Citizen of What Country? 10e, Street and Number Funeral 21047 USA 2821 Fallsmont Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 Yes 2XNo Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mean injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company 12 Associate Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Viola (unk) Heutel Ralph Harry Benway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2821 Fallsmont Drive, Fallston, Maryland 21047 Barbara Benway / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp: 8/12/2011 Towson, Maryland 4 Donation 5 Other (Specify) Funeral Service consee 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KINSONS Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine rany, leading to in resilate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 Yes 2 g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Light of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

201

AUGUST

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

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32 Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSTINE PREIS, CRNP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 07729/2011 4:45p м **Physician** Elsie Bell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Future Care Baltimore Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 93 Yrs. 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🕏 F Days Hours Min 057.08/91919 212-26-7395 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "neturel", or items 23a or 28e-f shov other treumstic event, the Medical Exprimer insel by notified at MD Baltimore Baltimore Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3628 East Fayette St 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nurse Aide Nursing Home 6yrs permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy importent; if Item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Kennly Viola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3628 East Fayette St Baltimore MD 21224 Maxine Hubbard Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/4/2011 Glen Burnie MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilitySimplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee noms ThomasAllenPA 7090 Ridge Rd Hanover MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has 2 No 1 Yes 1 Tes 20 No or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospitei t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

address of person who comp

32. Registrar's Signature

n Woods Road MD21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 0511 Bollhorst Charles William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBURG VICOMICO MEDICAL TENINSULA If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Aug. 13, Year 932 Mary Land Director 78 218-28-4065 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Hydes Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21082 U.S.A. <u>5004 Hydes Road</u> within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner Parking Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည **Bollhorst** Alma Fritz Blumberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50<u>04 Hydes Road</u> Mary K. Bollhorst Hydes, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 8-15-2011 Towson Mary land 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 of Funeral Service Lie 22. Name and Address of Facility 1050 York Road to a a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Physician/ Cereb -Ovas cule disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) led by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 24 No 2 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifi D63199 dress of person who completed cause of death (Item 23a) (Type, Print) 910 E. Shore Dr. 542156414 VOhCA M.D. 32. Registrar' Signatur State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Bennett 2011 2:20 P. M August Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1324 Meadowvale Road Glen Burnie Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 219 22 7145 1 XM 2 F (Month, Pay, Year) 28 82 Marvland Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at **Funeral Director** Glen Burnie Maryland Anne Arundel 1 Yes 2 XNo 10f, Zip Code 5 10e, Street and Number 10g. Citizen of What Country? 23a 1324 Meadowvale Road 21060 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. <u>-</u> þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White "natural" Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Crane Operator Bethlehem Steel Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be William Bennett Frances Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Bennett / Wife 1324 Meadowvale Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 08/08/2011 Matthew Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. ghway Baltimore, Maryland 21225 4001 Ritchie Highway monucen 23a. Pm 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con e uence of): **Examiner** Sequentially list conditions, if any, leading to minimal attacture. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a conscouence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Thinknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has ' autopsy performed? death? this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the Suicide 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours and To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WP 1600 S. Crain Husy Wu 106 Day, Year) 32 Registrar's Signature State AUG 1 Registrar

3altimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		for State Registrar	State of M	aryland / Depa	artment of he rtificate of De			2011	25582
Physic	ian/	1. Decedent's Name (First, Midd	e, Last) Carroll				2. Date of Deatl Month	Day Year	3. Time of Death 5:30 P M
Med Exam		4a. Facility Name (if not institution	·		4b. City, Town, or Lo	ocation of Death	July	28 2011 4c. County of Death	
		4321 Plainfic 5. Social Security Number		e (In yrs. last birthday)	Baltin If Under 1 Year	NOTE If Under 24 Hrs.	8. Date of Birth	Baltimo	
Funera Directo		157–30–1582 Usual Residence of Decedent	1 M 2 F	71 Yrs.		Hours Min.	(Month, Day, 12–26–1	939 Ne	hplace (State or Foreign Intry) W York
: Maryland 28a-f show notified at	Director	10a. State 10b. County Maryland Bal	timore City	10c. City, Town or Lo	nore				10d. Inside City Limits
with the 23a or 1st be r	Funeral C	10e. Street and Number 4321 Plainfi	eld Avenue		10f. Zip Code 21206			Og. Citizen of What Co. United State	-
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ※ Divorce	If You Give	X Vo	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2【】No		ify Yes or No- lican, etc.)	14. Race - Amer Black, White Specify: WH	e, etc.
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ore, of Heal of Heal of Heal		20a. Method of Disposition 1 Burial 2 Cremation		20b. Place of Dispo			<u>_</u>	20c. Location - City or	
T a le la	.,	4 Donation 5 Other	Specify)	Metro Cre	ematory INC				, Maryland
Balti permit. Departr Imports any inju		21. Sign were of Fun ral Service	M. Jones	ng 29)9 Frederic	ck Road,	mation S Balto,	Society Of 1 MD 21228	Maryland INC
Physician Medica Examine	1	23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that cause only one cause on each lin a. Due to (or as	EATIC N	er the mode of dying, s EaphAS VA — SEA	TIC C	respiratory arres	st,	Approximate Interval Between
760 icate be executed physician and stree burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as	a consequence of)	EMBO	1			MONAY
ox 68 ath certif attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ords, P.O. Be requires that the de been signed by the should be detached	P S	Part II. Other significant condit	VEIN TO	but not resulting in the C	Inderlying cause given	in Part I.		es 2 No 3 Pr	the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a s	Completed	•					24a. Was ar autops perform	prior to death?	topsy findings available completion of cause of
/ital sician: certific irector,	Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:		_ Other	e of Death (Check		а П он то	w.,
Division of Vital Rec to the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	cate: To	27. Manner of Death 1 Natural 5 Pend	28a. Date of inju		28c. Injury at work?			nce 6 Other (Speci w injury occurred	<u></u>
Division of Attermental of Attermental Director of in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	I not be	ury - At home, farm, str c. (Specify)	eet, factory, office	2	8f. Location (Str City or Town	reet and Number or Rur , State)	ral Route Number,
Hospita Hospita 24 hours Funeral	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e	examination and/or inves	tigation, in my opinion,	death occurred at t	the time, date and	d place, and due to the o	cause(s) and manner stated
To the I within 2 To the I complex	Ž	only one) Certifyin 29b. Signature and title of certifie	g Nurse Practioner: To the	T S A	29c. License nu			cause(s) and manner as 9d. Date signed (Month	
		30. Name and address of person L. Dwight Woos				ore Mar	viland 2	1287	
* St	ate	31. Partied (Month, Day, Year)	32. Registr	ar's Signature	c., Darelli	ole, mal	yranu Z	1201	
Regist DHMH 17 Rev 7		11 2011	anna J.	faces		_			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{ea} AŬĜUST PRESTON CAPEL 10:52PM DONALD Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** LANHAM PRINCE GEORGE'S 4229 KINMOUNT ROAD 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days OCT. 31 Months Hours 1 🛣 M 2 🗆 F 1941 NORTH CAROLINA Director 69 240-58-9122 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must hammistal and any injury or other traumatic event, the Medical Examinar must hammistal and any injury or other traumatic event. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** 1 X Yes 2 No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4229 KINMOUNT ROAD 20706 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th LEGAL INSTRUMENTAL EXAMINER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ္ CAPEL PHILLIP MCCALL OMA JANE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 229 KINMOUNT ROAD LANHAM, MARYLAND 20706 CAPEL/DGT DONNA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY | 8/12/2011 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 😿 No Certificate: To 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Funeral Director: After this certificate of completed filled in by the funeral director, page within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
>
> JOCELYNE KOUATCHOU M.D. 4041 POWDER MILL RD # 600 CALVERTON, MARYLAND 20705 31. Date filed (Month, Day, Year) 2. Registrar's Signature AUG 1 1 2011

Koualchou, mi)

State

Registrar

(Check

29b. Signature and title of certifier

Jocelyne

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

163748

29d. Date signed (Month, Day, Year)

10,2011

AUGUST

			Please Amend #30	Type or Pri	nt in E	Black In 7/22/20	delible Ir	nk. Ensure	All Copie	s Are Lec	gible.	
		•	Please Amend #30 1 - State Amend Items Registrar	24a,26 pe	r dr.	g / Depa , g918 ,	ntment of .08/11/2 tificate of	Health and 011dhb Death	Mental Hy	giene Reg. No 20		25584
	sicia /ledic		1. Decedent's Name (First, Middle, Last Dixie Ma	rie Crous					2. Date of De Junt 2	ath	Year	3. Time of Death 5:04 AMM
Ex	amin	er	4a. Facility Name (if not institution, give s 110 Patrick's	court			4b. City, Town, Smith	or Location of Deat Sburg	h	4c. County Wasl	of Death	on
Fun Dire	_		010-76600	X 7. Age	e (In yrs. Ia Co	st birthday) Yrs.	If Under 1 Year Months Days			th Y Year Y 1944	9. Birthi Coun	olace (State or Foreign htry)
land	dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation				1	10d. Inside City Limits
he Mary or 28a-1	notifie	Director	MD Frede 10e. Street and Number	rick			Freder 10f. Zip Code	rick		10g. Citizen of	What Cour	1 Yes 2 No
h with t	nust be	Funeral	6408-F W	eacther b	v C	ourt	a	1703			15/	idy:
ire, Maryland 21215-0036 If and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show	Examiner r	اھ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	Vas Decedent of Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer o Specify:	pecify Yes or No- to Rican, etc.)		ce - Americ ck, White,	
21215-0036 within 72 hours after giene.	edical	Completed	15. Decedent's Ed (Specify only highest grad	ucation		(Give k	ent's Usual Occu ind of work done	during most of wo	rking	16b. Kind of B	usiness In	dustry
d 212 led within Hygiene.	t, the M		Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DC	NOT use retired	odian		C	FFIE	se
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Marylar 12 should be f Ith and Menta 27 is marked	ranmat	Ì	19a. Informant's Name/Relationship (Typ	pe, Print)	Tyc	19b. Mailin	g Address (Street	t and Number or Ru	erne ural Route Numbe	r, City or Town, S	State, Zip (Code) 21703
of Health	other t	ŀ	Denise Bick is 20a. Method of Disposition		20b. Pi		sition (Name of		Date unk	20c. Location	- City or To	7
Baltimore, permit. Page 1 and Department of Hee Important: If item			1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)			emetery, crem	atory or other pla	ace)		Allen	laur	LPA
Bal permi Depar	any in		21. Signature of prival Solvice License	Tha	ch	22.	Name and Addr	ess of cility	allach:	De :	Jess	18434 00. PA
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	j	,	resulting in death) Last	Due to (or as a	ı conseque	ence of):						
ox 68760 ath certificate be attending physic for use of the by	200	/Med	IF FEMALE:									
m 8 e 3	in lot nation	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pregnar Other (specify) _	ncy			te of delive onth	Day Year
ords, P.O. B.	5	2	Part II. Other significant conditions con	tributing to death bu	ut not resu	Iting in the un	derlying cause g	iven in Part I.	23e. Did to	/		ne cause of death?
w requires been		Completed	Renal V	Contribu	7	The	2 50		24a. Was	an 24b.	Were autor	osy findings available
Rec The la cate ha	hage								autor perfo 1 🗆 Yes	rmed?	prior to col death? 1 🔲 Yes	mpletion of cause of
Vital vysiciar vysiciar		lo Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	 nt 2	R/Outpatient	Ott	Place of Death (Che	ck only one) lome 5 🔯 Resid	lence 6 🗶 Oth	er (Snecify	Neice's
ision of Vital RÉCC Attending Physician: The law er death. ector: After this certificate has by the funeral director nane?			27. Manney of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,	y 2	28b. Time of injury	28c. Inju wor	ry at		ow injury occurr		House
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the Compilered filled in by the funeral director name 2 should be desponded.		l Certificate:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.		ne, farm, stree		yes 2 LINO	28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
Div To the Hospital or within 24 hours after To the Funeral Dir completed filled in		Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	er: On the basis of ex	amination a	and/or investic	ation, in my opini	ion, death occurred	at the time, date a	nd place, and du	e to the cau	use(s) and manner stated.
To the To the To the To the			only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: 10 the D	# O/O A	knowledge, de	29c. Licens			29d. Pate signer	d (Month, L	Day, Year)
- (3)		3	30. Name and address of person who con		1//			405/)	1 1	(al)	2011
1).0	State	3	William H. Convey		nas J		Drive	Frederio	k,MD 21	702		
	istrar		AUG 1 1 2011	Leven	1. 1	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death August 7 .^{Day}2011 Physician/ Chamberlain 1:20 P Ear1 Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1619 Spence Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 1 M 2 F 7. Age (In vrs. last birthday) **Funeral** May 10, Year) 949 Days Hours Country Director 218-46-7037 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director 1 😾 Yes 2 🗆 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral United States 21230 1619 Spence Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) fe. DO NOT use retired) Iron Worker Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Joseph Edward Chamberlain Annie M. Severe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1619 Spence Street, Baltimore, MD 21230 Brenda Chamberlain - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 □ Rurial 2 ☑ Cremation 3 □ Removal from State 20c. Location - City or Town, State Date 8-11-2011 Glen Burnie, MD Atlantic Crematory 4 Danation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, 21. Signatu 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph_sician/ lar carcinoma Hepatoce Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in reclate cause. Enter Underlying Drie to (or ex e noneequence of) sician and burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last iis certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 1 Yes 2 L 9 Unknown Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform After this certificate has 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 ER/Outpatient 3 DOA 1 Inpatient 2 filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 1 Yes 2 No Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title 2011

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25586 for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 6:02 AM Deborah Ann Cook AUAUST 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rosedaie Square Hospital Center Ltimore Franklin If Under 1 Year If Under 24 Hrs. **Funeral** ial Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 🗆 M 2 🗶 F Davs Hours 12008 Pay 957 Director 219-74-3927 53 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Funeral Director ral", or items 23a or 28a-f s Examiner must be notified Middle River Maryland Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21220 2219 Firethorn Road permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner musone. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lundy Hartsock Church Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Gode) 2219 Firethorn Road Middle River, MD 21220 Russell C. Cook - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gardens of Faith Cem. 08/10/2011 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute respiratory
Due to (or as a consequence of): disease or condition distress Medical resulting in death) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed det 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Severe COPD Completed 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available page 2 s has autopsy performed? prior to completion of cause of death?

1 Yes 2 No or Attending Physician: The this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Praggioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature 29d. Date signed (Month, Day, Year) H69248 of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin

DHMH 17 Rev 7/2009

State

Registrar

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Deporat

Square Drive Baltimore.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 8:40 PM ,2011 Jack Cammarata Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner OWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 84 Yrs. Funeral Months Hours March 26,1927 Mary land 220-12-4849 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified 1 Yes 2 No Ellicott Maryland Howard 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21042 9376 Carrie Way "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give1944-1946
Year or Dates. Black White etc. δ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore Maintenance Man 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Tuminnello ည Mary Louis Cammarata 1 and 2 should be the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 Ellicott City, Maryland 9376 Carrie Way Brother Louis Cammarata 20b. Place of Disposition (Name of Most Petal City Patory or other place)
Redeemer Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland 8-13-2011 Baltimore 4 Donation 5 Other (Specify) Name and Address of Facility Ruck Towson Funeral 1050 York Road Towson, Maryland Home, Inc. 21204 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disease, or complication Approximate shock, or heart failure. List only one c Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Physician disease or condition Medical resulting in death) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last ig physician and as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 attending | IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ BILATERAL PLEURAL EFFUSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC KIDNEY DISEASE STAGE 4 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has by page 2 s performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Hospital: Other: မ 1 X Inpatient 2 ER/Outpatient 3 E 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi

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State Registrar OSLER

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DRIVE

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON POH LIM, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Design	partment of Health and ertificate of Death	d Mental Hygie	ene . N2 N 1	25588
	Physici	an	1. Decedent's Name (First, Middle, Last)			07/19/2011	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	07	4c. County of Death	8.10 P M
	Examir	ier	Genesis ElderCare - Perring Parkway Center	Parkville	am	Baltimore	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Mi		(ear) 9. Birth	place (State or Foreign
	Director		217-40-8762 1 M 2 F 67 Yrs. Usual Residence of Decedent		April 14,	1944	Maryland
	rryland show	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	the Ma 28a-f	Director	MD Harford Edgewood 10e. Street and Number	104 7i- Code	10	a. Citizen of What Cou	1 ☐ Yes 2 ▼ No
	3a or		550 Meadowood Drive	10f. Zip Code 21040		USA	muy:
	r deatl	Funeral	11. Marijal Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cyban, Mexican, Pure Mex	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White,	
36	irs afte	by F	1 Mover Married 2 Married 1 Yes 2 Movo 3 Wildowed 4 Divorced 1 Yes, Give Year or Dates:	1 ☐ Yes 2 Mo Specify:		Specify: Blac	
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121	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade	Car Salesman		Automobile	Industry
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ylar	ould be Menta larked latic ev	10 E	Steiner Dorsey	Genevi	eve Lee		
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Market and the traumatic event, the Market and the traumatic event.			illing Address (Street and Number or Derrywood Drive			
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ii.	Page Iment Iant: If Jury or		i de bunar 2 🗆 Cremation 3 🗆 nemoval from State		29/2011 Ba	altimore, 1	Maryland
Ball	permit. Pages 1 Department of H Important: If ite eny Injury or oth		112541	22. Name and Address of Facility 4210 Belair Road I	Chatman-Hai Baltimore,		
3			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		iac or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A a. Due to (or es a consequence of):	YOU'LUI MIA			
	Examiner		MOOTRESSIVE	DECLINE IN GO	NDITION	/	
12	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	EPHALOPATHY			
My Co	e execuan and and irial-tra	Exa	resulting in death) Last Due to (or as a consequence of):				
8760	death certificate be executed e attending physician and of for use as the burial-transit	dical	La. DIABETES MI	ELLITUS			-
Homes	n certifi anding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
3 ° €	that the death certificed by the attending posterior detached for use as	Physician/Medical	in the past 12 months?	B ☐ Ectopic pregnancy D Other (specify)		Month	Day Year
13 9	requires that the een signed by th hould be detache	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
- J	equires	ted by	DYSPHAGIA, SEIZURE D	ISORDER	_ 1 ☐ Yes	2 □ No 3 □ Pro	bably 45 bnknown
3ec	The law rate has be	Completed	\ <u></u>		24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
ta	an: Th tificate or, pag		25. Was case referred to medical	00.79	performe 1 □ Yes 2	No 1 ☐ Yes	2 □No
₩ Po	Physicien: r this certific ral director, I	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	0	eath <i>(Check only one)</i> g Home 5 ☐ Residen		eify)
	Jing P	ion:	27. Manner of Death 1 A Natural 5 □ Pending (Month, Day, Year) 28b. Time (Month, Day, Year)	of 28c. Injury at Work?	28d. Describe how		
-	To the Hospital or Attending Physicien: The law requires tha within 24 hours after death. To the Funerel Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be det	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 ☐Yes 2 ☐No street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital of within 24 hours a To the Funerel D completely filled i		29a. Certifier 12 ertifying Physician: To the best of my knowledge, de	ath occurred at the time, date and pla	ace, and due to the car	use(s) and manner as	stated.
(5)	thin 24 the Fu the Fu mplete	Medical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	20a Liganos numbos		L Data airand (Manth	Day Vand
	7. ≥ 7. ⊗		The Contract of the Contract o	29c. License number	§ 5 ²⁹	d. Date signed (Month 1/2 9 201 /	, Day, Teal)
_	5		30. Name and address of person who completed cause of death (Item 23a) (Type DIMITLA MITSANI 82 N.C.		271MORE	NO 21	20)
	Stat Registra		31. Date filed (Month, Day, Year) AUG 11 2011 32. Registrar's fignature are				

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O. I

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State of Maryland / I - State Registrar		cate of D			201		25590
	Physicia	ın	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		/ear	3. Time of Death
**	/Medic	al	Earl Joseph Dieringer, Jr. 4a. Facility Name (If not institution, give street and number)		City Town or I	ocation of Death	August .	5, 2011 4c, County of	Death	7:15 A. ^M
	Examin	er	720 Nottingham Road	45.	Baltim			,		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit		Inder 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	Count	lace (State or Foreign try)
	Director		185-16-1629 ¹⊠™ 2□ F 88	Yrs.	Titilo Days		March 10	, 1923	Penn	sylvania
	land ow	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Location	n				10	Od. Inside City Limits
	Mary	tor	MD Ba:	1timor	e					1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number		f. Zip Code		10	g. Citizen of Wh	at Coun	try?
	ath wi	ral	720 Nottingham Road		212		7 M N.	USA 14. Race		an Indian
920	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dight Examinant be positional	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Was Decedent Ever in U.S. Armed Forces?	13. Was L If Yes	Jecedent of His , specify Cubar es 2 X No	spanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)		White, e	
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind)	s Usual Occupa of work done di OT use retired)	uring most of worki		6b. Kind of Bus	iness/Inc	lustry
21	filed within Hygiene. other than '	Соп	4	Sa	1esman		(F) (14: 11) A	Autom		e
and and	be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last) Earl Joseph Dieringer			18. Mother's Name	zabeth A		,	
ž	d 2 should be f Ith and Mental I 27 Is marked of traumatic eve	ျှ		9b. Mailing Ad	dress (Street a	and Number or Run			State, Zip	Code)
<u>8</u>	and 2 s Health ar In 27 Is		(1)		'	at Drive				
re,	of Hea		20a. Method of Disposition 20b. Place cemetr	of Disposition	Name of y or other place	e) [Date 2	0c. Location - C	lity or To	wn, State
Ē	Page ment ant: If ury ol	1		ison Fo	rest	8/11/		Owings		
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.	1	21. Signature of Funeral Service Victories	Fun	eral Ho 30 Edmo	s of Facility Ste ome of Ca ondson Av	tonsvill enue: Ca	e, Inc. tonsvil		
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the	e mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	MC A	JON SA	4LL CEL	L LKN	19 CAN	CEC	9 months
-	/Medical Examiner		Due to (or as a consequence	e of):						
E		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e oi).						
20	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c							
0,0	e be executed sician and burial-transit	I Ex	resulting in death) Last Due to (or as a consequence	e of):						
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O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		topic pregnancy ner <i>(specify)</i>	/		23d. Date Mon		ery Day Year
σ.	uires that the de signed by the a d be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	j in the underl	ying cause give	en in Part I.				he cause of death?
0.0	w require been si should b	eted					-			opsy findings available
Vital Records,		Completed					24a. Was ar autops perform 1 🗆 Yes 2	y p ned ₂ ? d	rior to co eath?	ompletion of cause of 2 □No
Vita	sician: The certificate I rector, page	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othe	26. Place of Deat				
ō	Phys r this ral dir	To	I Inpatient 2 EN/C	Outpatient 3 b. Time of	28c. Injury Work	4 LI Nursing Ho	ome 5 Reside 28d. Describe ho			<u>fy)</u>
on	nding F ith. :: After e funera	atior	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury I		í? Yes 2 □ No				
Division of	or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, f	factory, office		28f. Location (St. City or Town		er or Run	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occ and/or investi	curred at the tir	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place, a	nner as and due i	stated. to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier		29c. License			9d. Date signed		
	.		> Zw love MD		DI	6354		8/8	120	211
	140		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print 900 C	ATON	AVE K	BALTIM	ORE H	UD.	21229
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1. See	Ker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Vacre 07:11 AM Jawi ce 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Center Bultimore Johns Hollins Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 2 - 8 - 1946 Hours Min. 1 M 2 X F Country) Maryland 214-44-4225 65 Director Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Anjeu Reuss Court 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Security Gypsum Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Caroll Grebe Catherine Lubinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Dacre/Grandson 516 Bayside Drive Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-13-2011 Dundalk, MD Rosary Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician Failure Heart days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner monny Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760

Physician/Medical Certificate: To Be Completed by IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🛛 No 2 🗌 No Yes 25. Was case referred to medical

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, this certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, i To the Hospital within 24 hours a To the Funeral L 3

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Res - 000 august 08, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other:

1 🔲 Yes

28c. Injury at

26. Place of Death (Check only one)

2 No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

State Registrar

Medical

MD.

2 **N**o

5 Pending

Investigation

6 Could not be

1 Tes

27. Manner of Death

1 Natural

2 Accident
3 Suicide

Suicide

Eastern Luenue Baltimore

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month August Physician/ 1401 F. 4equokun 2011 Medical 4c. County of Death
BOITIMEN 4a, Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner Randalls town Northwest 9. Birthplace (State or Foreign Country) Nigeria 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Month, Day, 1 🗆 M 2 🕱 F Months Hours 214.51.08 Director Usual Residence of Decedent ns 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Funeral Director Owings Mills 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21117 Caks Bradiside 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry State of Manyland 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Division of Juvenile) SNOS tssistant Kesidential 12th arado Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Okotie -Confort Name Evengho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (HUSpunc)) Department of Health ar Important: If item 27 is any injury or other trauonce. Oaks Owings Milb MD21117 Erumanuel W. Eveguckan Broduside 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Nigeria 1 A Burial 2 Cremation 3 Removal from State Warrin Jaghalla 4 Donation 5 Other (Specify) Vaughn C. Greene Funeral services Signature of Funeral Service Licensee 22. Name and Address of Facility Randallstown MD 21123 8728 Liberty ad 23a. Part 1. Ent of the visease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician/ disease or con the resulting in death) Medical Due to (or as a consequ + ice of): **Examiner** Sequentially list conditions, if any least light immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to or as a consequence of physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the at d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown ASTHMU Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b irector, page 2 sl autopsy death? perform 2 17 110 Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Suicide Investigation 6 Could not be after death Director: / 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO062650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOI anveer (raibi 5401 old court road Randalistown MD 31. Date filed (Month, Day, Year) AUG 1 1 2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2011 8:30A M August George Amos Evans, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 9414 Penfield Road Columbia 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12-12-1928 1 **X** M 2 □ F Maryland 82 213-26-9693 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Funeral Director 1 🗆 Yes 2 🔽 No MD Howard Columbia 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 9414 Penfield Road 21045 12. Was Decedent Ever in U.S. Armed Forces?

1 双 Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify U.S.A. 1 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Business Owner 6+ rchitectural Engineer Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Katherine Virginia Scribner George Amos Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Columbia, MD 21045 9414 Penfield Road (Wife) Tatiana Evans 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 □ Cremation 3 □ Removal from State Marriottsville, MD Crestlawn Memorial P: 8-9-2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur f Funeral Servi 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, MD 21045 5555 Twin Knolls Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ep Ph_sician/ Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death Day in the past 12 months? Month Year Pregnant at time of death 2 No g | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy s certificate has director, page 2 a perform death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 2 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28d. Describe how injury occurred Natural 5 Pending Accident Investigation ☐ Accider☐ Suicide 24 hours after deatle Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar

31. Date filed (Month, Day,

AUG

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day lemin9 **Physician** Charles 94945+ 07 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 □ F 218-44-6315 Usual Residence of Decedent **Director** Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2 No Funeral Director MN 10g. Citizen of What Country? USZ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? White, etc. Examiner Yes 2 Thes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify. <u>გ</u> 3 Widowed 4 Vivorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d other than "natur went, the Medical I 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) may 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suman Be Is marked ည 19b. Mailing Address (Street and Number or Rural Route Number, Col. or Town, State, Zip Code 21162 ame/Relationship (Type, P permit. Pages 1 and 2.3
Deportment of Health ar
Important: If Item 27 is
any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses NO1563 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Se **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of: Examiner 0 Sequentially list conditions, if any limit in the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Fctopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 2 710 1 Tes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 - ER/Outpatient 3 - DOA မ this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director Aft completely filled in by the fu 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of pere n who completed cause of death (Item 23a) (Type, Print) ٤ PETERS MATTHEN 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) AUG 11 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25595 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Month Physician/ 9:45 PM Lillian J. Franus 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ballimore Hookins Elderolus Assisted Living Himore 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign cial Security Number **Funeral** (Month, Day, Y Min. Months Hours 1 □ M 2 🗓 F Yrs Director Pennsylvania 207**–**10–6647 Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits with the Maryland at 10a State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified a 1 Yes 21 No Dunda1k Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21222 United States 3 Graywood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11 Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 years Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Miller 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pocasset, MA 02559 (Guardian) 25 Kenwood Road Robert Dwver 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8/6/2011 Middle River, Maryland Holly Hill Mem. Gdn. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc 21. Signature of Funeral Service Licenses 7922 Wise Avenue Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ advanced demantia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown diabetes, HTN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 N certificate 1 🗌 Yes _2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify) assisted line ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes 2 🗌 No Accider
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Himore

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	larylan		rtment of H			211		25596
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	uncate of D	Gaur	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		Grayson	Eugene	म	rancis	:		August	Day	Year	9:15 a ^M
	Medic Examin		4a. Facility Name (if not institution,			TOTIO	4b. City, Town, or	Location of Death	riagase	4c. County	of Death	7 7 7 7
		•	1507 Bulls Lane	9			Joppa			Harf	ord	
	Funeral		· ·	6. Sex 7. Ag	ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birthp	place (State or Foreign
35	Director		216-20-2858 Usual Residence of Decedent	T ZOL WIZ LIF	83	Yrs.	,		Mar. 18			Maryland
	show d at	or	10a. State 10b. County		10c. City	, Town or Loc	ation				1	0d. Inside City Limits
	naryla Ba-f s tified	rect	Maryland Har	ford	Jop	na						1 🗌 Yes 2 🖾 No
	the h	Ē	10e. Street and Number	1014	1 000	<u> </u>	10f. Zip Code		T	10g. Citizen of W	√hat Cour	ntry?
:	s 23a	Funeral Director	1507 Bulls Lan	e			21085			USA		
	death item ner n		11. Marital Status	12. Was Decedent Armed Forces?		i. 13. V	Vas Decedent of His Yes, specify Cubar	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White, e	
36	s filed within /2 hours after death with the Maryland Hygiene. 4d other than "natural", or items 23a or 28a-f shc event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🖾 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 XYes 2 If Yes, Give Year or Dates.	No	1	☐ Yes 2 🔀 No	Specify:		Specify:		
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7	with giene Jer th t, the		7			Prep	Line Ope	erator		Steel	Manu	facturer
ם י		To Be	17. Father's Name (First, Middle, L.	•				18. Mother's Nam)	
<u>≅</u> :	should be file h and Mental 7 is marked o raumatic eve		Charles Thomas			T		Dixie Ge				2 (1)
Z S	2 shou th and 27 is m traum:		19a. Informant's Name/Relationsh Anna Francis /			1	g Address (Street a Bulls La				rate, ∠ip C	Joae)
<u>ئ</u>	I and 2 s f Health item 27 other tra		20a. Method of Disposition	MITE	20b. P	lace of Dispo	sition (Name of		Date Date	20c. Location -	City or To	own, State
JO L	Page 1 ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		~ 		natory or other place emorial G	i	12-11	Bel Air	. Ma	ryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Sign tun of Fundal Service L		рсл							
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£	nysician/	1	Immediate Cause (Final disease or condition	· Mu	55tati	c hu	ig land	ac .			- 2	Onset and Death
bepare .	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	V -)				
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6876	ng ph as th	Med	IF FEMALE:									
9 ×	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Feta	I death 3	Ectopic pregnancy	/		23d. Dat Mo	te of delive	ery Day Year
Box	by the at tached fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant 9 ☐ Unknown		leath 5 ∟	Other (specify)			IVIO	TICIT	Day Tour
Records, P.O.	ed by detacl	/ Ph	Part II. Other significant condition	ព្ទs contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to the	ne cause of death?
S,	v requires trat s been signed t should be det	d by	Cororan	Voly Distor	†				1 🗆	Yes 2 □ No	3 🗌 Pro	bably 4 Unknown
ord	y required should should	Completed	(ľ					24a. Was		Nere auto	psy findings available
္တ	Fnysician: The Taw this certificate has al director, page 2 ?	mo							autor perfo	rmed?	death?	mpletion of cause of
<u>a</u>	rtifica tor, p	BeC	25. Was case referred to medical examiner?				26. Pla	ce of Death (Chec		2 921 1401		
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o i	aing Fin th. After thi funeral o	ate:	27. Man or of Death 1 Natural 5 ☐ Pendin	28a. Date of inj (Month, D		28b. Time of injury	28c. Injury work?	?	28d. Describe h	ow injury occurre	ed	
Sior	trend death stor: / the f	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	not be	ium - At ho	mo form etr	M 1 L 'eet, factory, office	Yes 2 No	20f Leastian /	Street and Numbe	or or Pum	I Pouto Number
Division of Vital	II or Attend after death Director: A d in by the f	Çe	4 - Homicide determ		tc. (Specify		set, lactory, office		City or Tou		a oi nuiai	r noute rumber,
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:	To the Propriator Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		xaminer: On the basis of Nurse Practioner: To th								
_ ;	with To the com		29b. Signature and title of certifier	11 (1		29c. License	number		29d. Date signed	d (Month,	Day, Year)
			High	D. midd	Sum		1 149	0183		8/4/1		
rl	(2)		30. Name and address of person v	who completed cause of	death (Item	23a) (Type, F	Print) G.	220 B	011: A	V DIDIE	-	
' '	Sta	0	31. Date filed (Month, Day, Year)	32. Remain	var's Signat	ture	THA UH	WW.	al the	al alvil		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25597 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yrone Ford A Month 7:05 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOIL Itimore **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🔀 M 2 🗌 F Hours Min. (Month, Day, Year) 196 -19-801 Director Country) M Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pine. 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Himore 1 Yes 2 No and Number 10g. Citizen of What Country? 122 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Yes, Give Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. 3 Divorced 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OOK 10th Be 17. Father's Name (First, Middle, Last) ည enc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owando 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Sc 22. Name and Address of Facility 21223 enue MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Onset and Death Colon cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Pregnant at time of death Month Year 1 Yes 2 No 9 Unknown certificate has been signed by irector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No ပု this 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \sum Yes 2 \sum No Director: After 28d. Describe how injury occurred 1 Matural 5 Pending death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

MS LAPUMLM D 29d. Date signed (Month, Day, Year) DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MO 21209, S. Rajapakse M.D. 2835 Smith AV 5-203

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

			For State of Maryland / Dep				0011	05500
		-	Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of I	Death	2. Date of Death	g. No	25590
	Physicia Medic		Rita Gorman			Month Aug	Day Year	3. Time of Death 11 12:18 P M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, c	or Location of Deat		4c. County of De	ath
أوالمالية			St. Martin's Home	Catons			Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔀 7. Age (In yrs. last birthday 1 ☐ M 2 🔀 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ M 2 ☐ 7. Age (In yrs. last birthday 1 ☐ 7. Age (In yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. B	irthplace (State or Foreign ountry) NY
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No	 Was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2 ☒ No 	an, Mexican, Puert		14. Race - Am Black, Wh Specify: W	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of t	estigation, in my opini	on, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.
	Voit To 1		29b. Signature and title of certifier	29c. Licens		29	d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	47		JUN UJT	0,2011
			SAMBANDAM BASKARAN 3455 L 31. Date filed (Month, Day, Year) 32. Registrar's Signature	VILKENS	- AVE	BALTIM	DRE M	8,2011 D21229
	Stat Registra		AUG 11 2011					

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ichael Lee Go	Das	on State of Maryland A				ental Hygiene		2011	25599
170		Registrar	Cer	tificate d	of Death		Reg. No.		
Physici ledical Exam		Decedent's Name (First, Middle,Last) Michael Lee Goodson As Facility Name (if not institution, give street and number)				2. Date of D Month August	Day	Year	3. Time of Death 1256 hrs
		 Facility Name (if not institution, give street and number) 502 Goldspire Circle 			4b. City, Town, or Location Frederick	on of Death		. County of Death rederick	
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. la	ast birthday)	If Under 1 Year If Ur	nder 24Hrs. 8. Date of	Birth(MM/	DD/YYYY) 9. Birt	hplace (State or
Director		446-62-3541 1KM 2 F	51	Y	Months Days Hor	urs Min. Apr.	15,	1960 Foreig	n ^{untry)} Virginia
any .		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Loca	ation				10d. Inside City Limits
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ırylanı ta-f st	턍	10e. Street and Number	FI	edelic	10f. Zip Code		10a. Citi	zen of What Cour	
or 28	Director	502 Coldanina Cirala			21703				,.
with t	교	502 Goldspire Circle 11. Marital Status 12. Was Decedent	Ever in U.	S. 13. W	/as Decedent of Hispanic (Origin? (Specify Yes or	USA No-	14. Race - Americ	can Indian, Black.
leath r item	Funeral	1 Never Married 2 Married Armed Forces?	X No		Yes, specify Cuban, Mexic			White, etc.	,,
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1110	1	Yes 2 X No speci	ify:		Specify: Whi	te.
ours a	₽ P	15. Decedent's Education (Specify only highest grade com	pleted)		ent's Usual Occupation (Givenst of working life, DO NO			(ind of Business/I	
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15-0036 filed within 72 ho Hygiene. d other than "nu , the Medical Es	Completed	17. Father's Name (First, Middle, Last)		Air I	raffic Contr	Coller ner's Name (First, Middle		S. Gover	nment
215-0036 be filed within 72 hours after death with the Maryland mall Hygiens rede other than "natural", or items 23a or 23a-f and eat, the Medical Examiner must be notified at once	Be C	Howard Raymond Goodson			100	elma Frances			
21215-0036 und be filed within 7 Mental Hygiene. marked other than	ToE	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street and N				Zip Code)
MD d 2 sho lith and n 27 is		Gerald M. Kreiner / Friend		305	Leoni St., N	lew Smyrna 1	Beach	, FL 321	.68
Te, land Heal Fitem		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta		Place of Disportenatory or o	osition (Name of cemetery,	Date	20c. I	Location - City or	Town, State
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alti rmit. spartm sports jury o	-	21 Signature of Funeral Service Licensee	٨		Name and Address of Fac Comas Funera 17 Cokesbury				
		Helly Milman to	15	13	17 Cokesbury	Road, Abii	ngdor	, MD 210	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter	the mode of dying, such as	s cardiac or respiratory	arrest, sho	ock, or heart	Approximate Interval Between Onset and
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	Examiner	(Disease or injury that initiated events resulting in death). Last	quence of):					
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Box 68760, death certificate be he attending physici of for use as the buri	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	ne of pregr		etal death 3 Ecto	pic pregnancy	230	 Date of delivery Month D 	ay Year
ox 6 th cer ttendi	sicia	past 12 months? 1 Yes 2 No 9 Unknown	time of dea	nth =	Other (Specify)				
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Division fal or Attendi rs after death. al Director: A	Certification:	Suicide Could not be determined (Specify)	ury - At ho	me, farm, str	eet, factory, office building,	etc. 28f. Location or Town		nd Number or Rur	al Route Number, City
Cospital Tospital Thours Tuneral	ပိ	29a. Certifier	knowleda	e death acc	urred at the time, data and	place, and due to the ea	1100(8) 00	d manage on state	-
Division To the Hospital or Attendia within 24 hours after death To the Runeral Director: A completely filled in by the fi	Medical	one) 2 Wedical Examiner: Dn the basis of exam and manner stated.			ation, in my opinion, death	occurred at the time, da			
	Σ	29b. Signature and title of certifier			29c, License numb	er		Date signed (Mon	th, Day, Year)
		V-1901-			O.C.M.E.		Aug	ust 3, 2011	
		30. Name and address of person who completed cause of de Donna M. Vincenti, MD Assistant Medic		,) W. Baltimore Stree	et, Baltimore, MD 2	21223		
Si Regis	tate trar	31. Date filed (Month, Day, Year) 32. Replaced AUG 1 1 2011	s Signatur		arks)				
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A SOURCE ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ahra Poly 1 Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ₹M 2 ☐ F (Month Day, Months Days Hours Min Country) 1939 New York 115-30-2468 72 Director Mar Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Cape Canaveral Florida Brevard 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 32920 United States 5807 N. Banana River Blvd., #1245 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No 1958If Yes, Give Black, White, etc. o, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 Widowed 4 Divorced Completed 1966 Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Verizon Cable Splicer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be Maynard Hamilton Dorothy Rockafellow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other training. 5807 N Banana River Blvd.,#1245, Cape Canaveral, FL Teresa Hamilton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 08/11/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 9 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? 5 Other (specify) Month Year Dav Pregnant at time of death signed by the a 2 No. Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Hospital or Attending Physician: The law has performed Yes 2 certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🕱 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation □ Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 214-1

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ TRICK LEONARD Month HOWARD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) unk **Funeral** 8. Date of Birth Year 1941 Days Hours Min. July 16, **Director** 214-38-4117 70 Usual Residence of Decedent or 28a-f show 10b. County 10a. State injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA items 23a 21230 1729 Hanover St. 11. Marital Status Unic 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 XX ever Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UTAK
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) **Painter** Home Improvement lyr unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည Cleta Fergus Pleasant L. Howard 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Calvert St #300; Baltimore, MD 21202 Cassandra Lucas - guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 5 Donation 6 8/14/2011 Atlantic Crematory Glen Burnie, MD Simplicity Creme Fun. Ser, Thomas Allen P.A. Signature of Euneral Service License Ronal Id S 7090Ridge Kd. Hanover MD 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause meach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a consequence of) requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events reumonia Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🕽 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred Natural 5 Pending work' s after death.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Sign 29d. Date signed (Month, Day, Year) 08/06 2011 s of person who completed cause of death (Item 23a) Type. Print re #203 Baltin

Registrar
DHMH 17 Rev 7/2009

State

AUG 1 1 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:30 AMM July 22, 2011 /Medical James Edward Havey 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll 1140 Lafayette Drive Sykesville 8. Date of Birth (Month, Day, april 3, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** ^{Year)} 1955 Days Months Hours 1 X M 2 □ F april **Director** 215-68-5141 56 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Evandary and the notified at 1 Yes 2 No Sykesville Carroll **Funeral Director** MD 10g. Citizen of What Country? 10f. Zip Code 21784 10e. Street and Number 5 1140 Lafayette Dr. items 23a 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Specify: white ь Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) engineer 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Margaret E. Deck Ralph Stanley Havey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1140 Lafayette Dr; Sylesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) Stacy Havey - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Euneral Sorvice Licensee Ronald S. Wade ✓ Director 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between 23a. Part it. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Esoplaged **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specity) Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check of one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu of certifier Name and ddress of person who completed cause of death (Item 23a) (Type, Print) State Registrar

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		1- For State Registrar		rtificate of				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.	201	25603
Physicia	an/	Decedent's Name (First, Middle,Last)					•	2. Date of D	eath	Year	3. Time of Death
edical Exami	ner	Loretta Hall							4, 2011		1911 hrs
		4a. Facility Name (if not institution, give Harbor Hospital Center	street and number)		4b. City, Tow Baltimor		cation of E	eath	1	ounty of Deat	h
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday)	If Under 1		If Under 2	4Hrs. 8. Date of		N/A	thplace (State or
Director			M 2XF 80		Months	Days	Hours	Min.		Forei	
		214-26-3297 1 Usual Residence of Decedent	01	0 110	·]			11/4	4/193	<u> </u>	VA
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Maryland 28a-f show d at once.	ō	Md N/A		Baltim	ore						1 X Yes 2 No
Maryl 28a-	rect	10e. Street and Number			10f. Zip Co	de			10g. Citizer	of What Cou	ntry?
ith the Maryland 23a or 28a-f sho ootified at once.	Funeral Director	2333 Sidney AVe			212				USA		
death wir	nera	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in L Armed Forces?					? (Specify Yes or uerto Rican, etc.)	No- 14	. Race - Amer White, etc.	ican Indian, Black,
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "satural", or items 22a or 28a-f she natic event, the Medical Examiner must be softfled at once	To Be	George Paige 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street ar		rice Pa		or Town, State	e, Zip Code)
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Baltimore, permit. Pages I are Department of Her Important: If ite injury or other tr		1 N Burial 2 Cremation 3 Donation 5 Other Specify:	Lo	oudon :		Cem	. 8	3/12/20	11 Ba	ltimo	re, Md.
rmit.		21. Signature of Funeral Service Licens	ee / / /	22 N	lame and Add	Bru		s Fune			
	Щ	Cugine 117	Alka	1	300 E	uta	w Pl	ace, B	altim	ore, l	Md. 21217 Approximate Interval
Physician /Medical		A. Part I. From the disease, or simple failur. List only one cause on each	cations that caused the best	1, Do not enter t	ne mode of a	ying, suc	crias card	lac or respiratory	arrest, snock,	, or near	Between Onset and Death
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	iner	if any, leading to immediate	ue to (or as a consequence of	of):							
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be exountial -	dical	UNPENDED	AMENDED								
Box 68760, a death certificate be the attending physicied for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		tal death	3	Ectopic pr	regnancy		ate of deliver onth	y Day Year
x 6.	icia	past 12 months?	4 Pregnant at time of de	a oth	her (Specify)				2		
Bo ne dear the ar	hys	1 Yes 2 No 9 V Unknown	9 Unknown					20- 0	41-1		the cause of death?
ion of Vital Records, P.O. Beolion of Vital Records, P.O. Beath. cath. for: After this certificate has been signed by the the funeral director, page 2 should be detached	β	Part II. Other significant conditions	contributing to death but not	resulting in the t	indenying car	use give	en in Parti				bably 4 V Unknown
ds, land			-								utopsy findings available
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Re : The ficate		05 W				Diagram of	Darth (Cl	1 ✓ Yeneck only one)	s 2 No	1 🗸 Y	es 2 No
/ital	Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatient		10#		ursing Home 5	Residence	e 6 Othe	r:
of V g Phy fter th	<u>ا:</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I			at Work?		be how injury		
OD Sath.	tio	1 Natural 5 Pending			1	Yes	2 N	•			
Division of Vital Records, rad or Atteodiog Physiciae: The law require all or Atteodiog Physiciae: The law require all Director: After this certificate has been sited in by the funeral director, page 2 should be	ifice	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At h	nome, farm, stree	et, factory, off	fice build	ding, etc.		n (Street and	Number or Ru	ural Route Number, City
Divisior To the Hospital or Atteod within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined	(Specify)					31 7 3 W	, 5.3(0)		
he Hoo n 24 h ne Fur		29a. Certifier (Check only 1 Certifying Physicial Cone) Medical Examiner:	in: To the best of my knowled On the basis of examination a	dge, death occur and/or investigat	red at the tim	ne, date	and place	, and due to the c	ause(s) and nate and place	nanner as stat	ted ne cause(s)
To th within To th	Medical	29b. Signature and title of certifier	and manner stated.			cense n					onth, Day, Year)
	-	111. A	MA			C.M.				st 5, 2011	,
		30, Name and address of person who c	ompleted cause of death (Iter	n 23a)	<u> </u>	,	-				
/			sistant Medical Exami		/. Baltimoi	re Stre	et, Balt	imore, MD 2	1223		
	ate	31. Date filed (Moňth, Day, Year)	32. Jegistrar's Signat	3. par	1.1						
Regist	rar	AUG 1 1 20'	17 /bysum	d. Alak	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:25Pm Hall **20**11 Physician/ August 1191010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Halethorpe 2917 Delaware Ave. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Days Hours Dec Month, Day, Year) 942 MaryTand 68 **Director** 215-40-9456 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland | Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral united States 21227 2917 Delaware Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. ò 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation School Bus Driver 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary L. Crawford Thomas L. Claytor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ross A. Hall/ Husband <u> 2917 Delaware Ave., Halethorpe, Maryland 21227</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Maryland Aug. 8,2011 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signarure of Funeral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Sulphur Spring Rd., Arbutus, Maryland 328 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition resulting in death) in Medical Due to (or as a consequence of) Examiner TaTio Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed find 24 hours after death.

The Funcal Director: After this certificate has been signed by the attending physician and motered filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Ves 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

5401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

dd cowt Rd RandollsTown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oluan Claig Ho		1- For State Registrar	tate of Maryland	_	artment of rtificate of			аі пуді		g. No. 20		25605
Physici Medical Exam	an/	Decedent's Name (First, Midd							Date of Death Month ugust 7, 2	1	ar	3. Time of Death 0940 hrs
		4a. Facility Name (if not institution Assawoman Bay nea)	4	tb. City, T	own, or Location o		<u>agaot 7, 2</u>	4c. County		
Funeral Director		5. Social Security Number 213–31–9104		e (In yrs. 1	last birthday) Yrs.	If Unde	r 1 Year If Unde	Min	Date of Birth	(MM/DD/YYYY	9. Birt	hplace (State or nuntry) MD
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locati	on	-	1 1				10d. Inside City Limits
	JO.	MD Balts	imore	Ar	butus							1 Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Dire	10e. Street and Number 1245 Francis	AVe.			10f. Zip 21	Code 227		10	g. Citizen of Wi USA	nat Coun	ntry?
after d ul", or	by Fune		orced If Yes, Give Year or Dates:	X No	1	es, specif	nt of Hispanic Orig y Cuban, Mexican, No specify:	Puerto Rica	an, etc.)		e, etc. Whi	
5-0036 led within 72 hours: Hygiene. other than "naturi the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4 or		during mo		king life. DO NOT	use retired)		Water	Pro	
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than ite event, the Medica	æ	17. Father's Name (First, Middle Craig George 19a. Informant's Name/Relations	Hock ship (Type, Print)				Robi	in Tra	cy Sny	er, City or Tow	n, State,	Zip Code)
		Robin Snyder, 20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from St	ate	Place of Disposi crematory or oth	tion (Namer place)	cis Ave.	Da 8-12-	te	20c. Location - Glen Bi	· City or ⁻	
Baltimore, permit. Pages 1 at Department of Hee Important: Wite	3 2	21. Signature of Eaneral Service		1			 Address of Facility 	Amor		neral 1	Home	
Physician Medical Examiner	8 3	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.		. Do not enter th							Approximate Interval Between Onset and Death
ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or Injury that Indiated events resulting in death) Last	b. Due to (or as a cons	equence o	of):	_						
60, ate be executed hysician and e burial - transit	Medical E	UNPENDED	d AMENDED									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	23c. If yes, outcor 1 Live birth 4 Pregnant at		2 Fet	aldeath ner (Spec		pregnancy		23d. Date of Month		Ay Year
, P.O. E res that the signed by the be detached	2	Part II. Other significant condit	contributing to deat	n but not r	esulting in the u	nderlying	cause given in Par	t I.	er-mit-s			he cause of death? ably 4 Unknown
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Vital Rec sysician: The this certificate director, page	To Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatient		6.Place of Death (Nursing Ho		lesidence 6	Other:	Scene
ion of tending Pheath.		27. Manner of Death 1 Natural 5 Pence 2 Accident Invest	28a. Date of Inju (Month, Day Y Aug 7, 2011	iry ear)	28b. Time of In 0000 hrs	ijury 2	3c. Injury at Work?	loub		w injury occum ned and wa		ck by a boat
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Coul 4 Homicide			ome, farm, stree	t, factory,	office building, etc		or Town, Sta			al Route Number, City n City, MD
D To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of m miner:On the basis of exa	y knowled mination a	ge, death occum ind/or investigati	ed at the on, in my	time, date and plac opinion, death occ	ce, and due curred at the	to the cause time, date ar	(s) and manner nd place, and d	as state ue to the	d. cause(s)
To cor	Me	29b. Signature and title of certifie	and manner stated.			29c.	O.C.M.E.			29d. Date signe August 8, 2	•	th, Day, Year)
	1	30. Name and an resu of person Pamela E. Southall, M				W. Bal	timore Street	Baltimor	e. MD 211	223		
St Regis		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu					-,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	partment of Health and Nertificate of Death		2011	25606
			Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Death	Reg. 2. Date of Death	N&L U I I	3. Time of Death
	Physicia Medic		Helen Marie Hunger		Month Aug. 5	Day Year 2011	6:15 a. ^M
-	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	oirs a.
-	<u>, </u>		Gilchrist Center	Towson		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) Coun	
1		0	216-16-9412 87 Yrs. Usual Residence of Decedent		Oct. 15.	1923 Mar	yland
	/land f sho	tor	10a. State 10b. County 10c. City, Town or I	ocation		1	0d. Inside City Limits
	Mar 28a- notifie	Director	Maryland Baltimore Dunda				1 Yes 2 No
	ith th	ral	10e. Street and Number	10f. Zip Code		Citizen of What Cour	,
	ems ?	Funeral	3415 Loganview Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	21222 Was Decedent of Hispanic Origin? (Spe		ited State	
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ▼ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
8	urs af tural" al Exa	ted	3XXWidowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 💢 No Specify:		Specify: Whi	te
5	72 ho n "na'	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b	. Kind of Business Inc	dustry
212	ed within Hygiene. other thai		College (1-4 of 5+)	omemaker		Own Home	
þ	ent ent	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide		
ylaı	should be file and Mental had Mental had see see ranmatic eve	To	Andrew Cieprisy	Catherin	ie Lewando	wski	
Maryland 21215-0036	1 and 2 should be fi f Health and Mental item 27 is marked other traumatic ev		1 1	ling Address (Street and Number or Rura			
45	and 2 s Health tem 27	1	Maryanna Hunger (Daughter) 351a 20a. Method of Disposition 20b. Place of Dis	Royston Avenue E			
nor	age 1 ent of nt: If it		1 X Burial 2 Cremation 3 Removal from State cemetery, cr	ematory or other place)		Location - City or To	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otf			nislaus Cemetery 8/ 22. Name and Address of Facility		altimore,	
ä	Der limp	6	N) 2 ((() ()	Duda-Ruck Funeral 7922 Wise Avenue	Home of D	undalk, In	nc. 21222
		1	23a. Part T. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as	r respiratory arrest,		Approximate Interval Between
	Physician/	8 9	Immediate Cause (Final disease or condition	Chuknoun 7	i well	1	Onset and Death
-	Medical Examiner		resulting in death) Due to (or as a consequence of).		~		
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P.0	that t ned b e deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ds,	quires en sig ould b	ted I	Sepsis		1 🗆 Yes	2 No 3 Prob	pably 4 Unknown
COL	aw rec as be 2 sho	Completed by			24a. Was an autopsy		osy findings available mpletion of cause of
Re	The I				performed	? death? No 1 ☐ Yes	2 🗆 No
ita	ician certifi rector	m	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	only one)	N 20 - 20 -	0.5055
) V	Phys r this eral dii	e: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatt 27. Manner of Death 28a. Date of injury 28b. Time	ent 3 🗆 DOA 4 🗆 Nursing Ho	me 5 Residence 28d. Describe how in	6 Other (Specify	Hospice
Division of Vital Records, P.O.	nding ath. r: Afte e fune	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	Log. Describe now in	ijury decumed	\
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	Fo the vithin Fo the comple	Σ	29b. Signature and title of certifier	29c. License number		se(s) and manner as sta Date signed (Month, i	
			Shaheer.	00071287		-5-11	
	'	-	30. Name and address of person who completed cause of death (Item 23a) (Type thinks Shaheen, 6701 N. Charles				N. A.
		1	Thing Shaheen 6701 N. Chates.	st. Swite 4105	1 Daltin	mark' Wil	11204
	Stat Registra	e ar	31. Date filed Wonth Day Year AUG 11 2011 32. Jegistrar's Signature	harles			

Thomas Edward	Hip		ate of Maryland	/ Depa	rtment of H	ealth a			7.50	1 2560
Physicia	ın/	Registrar 1. Decedent's Name (First, Midd	, ,	Cert	tificate of D			2. Date of Dea	eg. No.	3. Time of Death
Medical Exami	ner	Thomas Edward	-		4b. (city, Town,	or Location of De	July 27, 2	011 4c. County of D	1157 hrs
/		526 Faiview Avenue 5. Social Security Number	6 Can 7 Acr	/la la	D	undalk			Baltimore 0	
Funeral Director		218-92-1522	6. Sex 7. Age	4 8		Under 1 Ye			1962 FG	Birthplace (State or reign Country)
Any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Location					10d. Inside City Limits
▶	5		timore	-	oundalk					1 Yes 2 No
seth with the Maryland items 23a or 28a-f show ast be notified at once.	Director	10e. Street and Number	7		10	Zip Code		1	0g. Citizen of What (Country?
with th	ralD	526 Fairviev	12. Was Decedent I	Ever in U.S			Hispanic Origin?	(Specify Yes or No	USA - 14. Race - Ar	nerican Indian, Black,
er death	Funeral	1 Never Married 2 MM 3 Widowed 4 Div	1 Yes 2	No			an, Mexican, Pue	erto Rican, etc.)	White, et	white
ours aft	d b	15. Decedent's Education (Spe		pleted)	16a. Decedent's U	sual Occup	lo specify: pation (Give kind fe. DO NOT use		Specify: 16b. Kind of Busine	
hin 72 h	Completed	Elementary/Secondary (0-12) 12yrs	College (1-4 or 5	i+)	Stee]			retired)	Steel	
e, MD 21215-0036 I and 2 should be filed within 72 hours afte Health and Mental Hygiene. Item 27 is marked other than "natural", traumatic event, the Medical Examiner.		17. Father's Name (First, Middle, Gerald Hipch					18.Mother's Na	me (First Middle, Midd	Maiden Surname)	
212' ould be in Mental	To Be	19a. Informant's Name/Relations			19b. Mailing Add	ress (Stre			ncy nber, City or Town, S	tate, Zip Code)
, MD and 2 sho ealth and em 27 is		Patricia Ann 20a. Method of Disposition	1 Hipchen w			irvi	ew Ave		k MD 212	24
MOre		1 Burial 2 Cremation	3 Removal from Star	te At I	ematory or other p antic (ace) Crem		/3/2011	20c. Location · City Glen B	surnie MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Sp. 21. Signature of Funeral Service					ss of Facility S	implici	ty Crem	& Fun Serv
Physician	1	23a. Fart I. Enter the disease, or	complications that caused t	he death. I	Thon Do not enter the ma	nasAl	lenPA g, such as cardia	7090 Ri	dge Rd H est, shock, or heart	anoverMD Approximate Interval
/Medical xaminer		failure. List only one cause Immediate Cause (Final disease	a Narcotic(l			cicat	ion			Between Onset and Death
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ansit de offi	Exa	events resulting in death) Last	Due to (or as a consect d.	quence of):						20
Ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	X UNPENDED	AMENDED 23a, 18, per fh	27, 28 , g 919	Ba-f, per 9-16-11	me,g9	19 9-9-	11 sm		
68760, certificate be nding physicise as the buri	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	e of pregna		ath 3	Ectopic pres	gnancy	23d. Date of deliver Month	very Day Year
	Physician/Me		nown 9 Unknown	ime of deal	th 5 Other (Specify)				
that the ned by ti	ē Ē	Part II. Other significant conditi	ons contributing to death	but not res	sulting in the under	ying cause	given in Part I.			to the cause of death?
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of V ing Phy After thi	읽	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Yea	v	28b. Time of Injury		ury at Work?		Residence 6 🗹 Ot	her: Scene
ision Attend or death. rector: by the f	icat		tigation 28e Place of Inju		fd 11:52 a		Yes 2 X No	Unknown		Rural Route Number, City
Div pital or ours after	Certification:	4 Homicide deter	a not be		of reside		building, etc.		ate) 526 Fai	rview Ave.
	Medical	29a. Certifier 1 Certifying Phone) 2 Medical Exar	nysician: To the best of my miner:On the basis of exam	knowledge ination and	e, death occurred a Nor investigation, in	t the time, on my opinio	date and place, a n, death occurre	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due to	tated.
et wir	¥	29b. Signature and title of certifie	and manner stated.			29c. Licen	se number		29d. Date signed (Month, Day, Year)
Bis:		30. Name and address of person	hasself M	ath /Itom ?	39)	0.0	.M.E.		July 28, 2011	
Orter.		Melissa Brassell, MD	Assistant Medical E	,	,	Itimore \$	Street, Baltin	nore, MD 2122	3	
Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	12.1					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea august 1245 A-M 2011 Margaret Alma Isennock 4b. City, Town, or Location of Death 4c. Coupty of Death 4a. Facility Name (If not institution, give street and number) If Under 24 Hrs 8. Date of Birth (Month, Day, Jan 19, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Days Hours 1 □ M 2 🛂 Months 1921 Virginia Jan." 90 217-16-6636 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 □Yes 2 No York Airville Pennsylvania 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 17302 9 Quiet Stream Lane 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 **N**O 1 Never Married 2 Married 1 □Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Minnie Pearl Edwards Alexander Frederick Burnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Quiet Stream Lane, Airville, PA 17302 Charles Isennock / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 8-11-2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Fune al Service Licenses Murlell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Caron Due to (or as a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a d Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Monurating Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No

/Medical **Examiner** Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examine and burial-tran attending physician for use as the buria √Medical ed by the a After this certificate funeral director, pag

Physician

/Medical

Director

Funeral

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Markel Examinat Demonstrated any injury or other traumatic event, Ire Markel Examinat Demonstrated any injury or other traumatic event, Ire Markel Examinat Demonstrated and gones.

Physician

Baltimore, Maryland 21215-0036

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within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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31. Date filed (Month,

2 Accident

4 Momicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Theresa Cecelia Jones 0819 1 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE, MD 195 8. Date of Birth
(Month, Day Yes 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Mary Land 219-20-8335 1927 Director 84 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State death with the Maryland Director 10c. City, Town or Location 1 Yes 2 No Baltimore MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21228 349 Whitfield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Specify: White 1 Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired; Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Geyer Mary Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 Dunes Drive; Ellicott City, MD 21042 Gary Jones Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 8/12/2011 Baltimore, MD Baltimore National 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fur eral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying ohysician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be exec physician Physician/Medical attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 2 **N**0 s been signed by the s should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of hypord 24a. Was an autopsy page performed' death? 2 410 certificate 2 W No Yes the tuneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) å Hospital Other: 2 1 No ျှ 1 Tes 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate:

Box 68760 P.O. Records, **Division of Vital**

Maryland 21215-0036

27. Manner of Death 1 Natural 5 Pending Investigation

28d. Describe how injury occurred

Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MID

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aton AVE Baltiroove, 0 31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

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within 24 hours at er death.

To the Funeral Director: A completed filled in by the fu

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Augüst ¹9,201¹1 Joseph Jelen 11:20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella <u>Maris Hospice</u> Baltimore Timonium 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Days Hours Min 214-22-6169 82 Maryland Nov **Director** Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo Md. Baltimore Hall Perry 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5008 New Forge Road 21128 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) EASTERN Elementary/Seconday (0-12) 12th College (1-4 or 5+) STAINLESS MACHINIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stefan Jelen Mary Bebnowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112819a. Informant's Name/Relationship (Type, Print) 2011 Perry Hall, Maryland 5008 New Forge Road Gerald<u>ine Koenig</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Augu&t 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State AUGUST 9, Holy Rosary Cem. 15, 2011 |Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A . Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit death certificate be executed Cause Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) for in the past 12 months? Pregnant at time of death been signed by the should be detached Unknown 9 Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes JOSEPH JELEN 24b. Were autopsy findings available 24a. Was an page 2 autopsy prior to completion of cause of this certificate has death? perforn 1 ☐ Yes 2 ☐ No ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ρ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred After injury work? 1 X Natural 5 Pending 2 🗌 No n 24 hours after death.

e Funeral Director: Ai bleted filled in by the fu M Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number 201 n who completed cause of death (Item 23a) (Type, Print) 30. Name and addre JONES, 2300 DULANEY VALLEY RD. TIMONIUM. MD 21093 32. Registrar's State 1 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25611 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 0800 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie 813 Seagrove Road If Under 1 Year I If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign X M 2 □ F Days Aug 18, 1943 Mary land **Director** 67 219-40-8697 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Glen Burnie MD Anne Arundel 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21060 813 Seagrove Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1960 - If Yes, Give 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 Widowed 4 Divorced Completed 1970 Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ye 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) transportation 12 Ò truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Eleanor Cromwell Thomas Leon Keenan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
813 Seagrove Rd; Glen Burnie, Maryland 21060 Elaine Dawn Keenan - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 - Other (Specify) Register License Signature of Funeral Se 22. Name and Address of Facility Board 21201 655 W. Baltimore St; Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death , or heart failure. List only one cause on eath line. Immediate Sause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a confiquence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): anding physician are use as the burial-Medical Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 atten signed by the a been si

s certificate has t lirector, page 2 s this nin 24 hours after death.

the Funeral Director; After thi
npleted filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	acedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	cause given in Part I.		use contribute to the cause of death?	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 10 1 Yes 2 No	
25. Was case referred to medical	26. Place of Death (Check only one)					
examiner? 1 Yes Marine	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e Place of Injury - At home form street factory office				8f. Location (Street and Number or Rural Route Number, City or Town, State)	
	ysician: To the best of my know niner: On the basis of examination				nd manner as stated. e, and due to the cause(s) and manner stated.	

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

State Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **AUG 11**

ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a. Per FH G918 8/19/2011 Jh State of Maryland / Department of Health and Mental Hygiene 25612 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPH Day 2011 RICHARD KNOTT SR. AUGUST 9. 7:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1512 Honeysuckle Drive Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 D F Mar 21, Year 1944 North Carolina 241-68-9443 67 **Director** Usual Residence of Decedent should be filed within 72 nous and and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show "....matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 Yes 2 X No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1512 Honeysuckle Drive 21014 USA 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Narried þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Company Truck Driver Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jesse Dolphis Knott permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Amy Elizabeth Drake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faith **F.** Knott / Wife 1512 Honeysuckle Drive. Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/12/2011 Towson, Maryland Six ury f Funeral Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 to hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se pn each line. Part 1. Enter the disease, or complic shock, or heart failure. List only one Approximate Interval Bet en Onset and I th Immediate Cause (Final Physician/ LUna disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate and I-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home No Hospital: ျပ 1 Yes Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury work / 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of e (Check ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nly or tilying Nurse Ps of my knewledge, diath annumed at the time date and place, and due to this causa(s) and manner as stated 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 16 ILICH C(N) DA 101 31. Date filed (Month, Day, Year) Registrar's Signature State ---Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Clifford 1:00 A M August 201 Medical 4b. City, Town, or Location of Death Randallstown 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** Seasons Hospice at Northwest Hosp. 9. Birthplace (State or Foreign Country) Virginia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Days 1 🙀 M 2 🗌 F 79 0170371932 225 30 5453 **Director** Usual Residence of Decedent 28a-f show For intit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other them. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore N/A Maryland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? U.S.10e. Street and Number 21230 2107 Parksley Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Catonsville Optical Optician Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ပ္ Jefferson Bishop Kiser Bertha Pannel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Melissa Rodriguez / Daughter 2107 Parksley Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/10/2011 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatu e of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway manuela 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Ph_{sician/} End-Stage disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other Specificat Nospice Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director; After thi
mpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: M Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nskajapahre M.b 00057465 8/5/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 5 - Rajarakse / MID 2835 Smith Baltimore ND-21209 5 203

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) AUG 1 1 2011 32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 [] For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 2011 07:00P M MIRIAM KAHN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) FRANCE 1 □ M 2 🗓 F Months Days Hours 10/31/191 99 Yrs **Director** 219-44-5530 Usual Residence of Decedent show ems 23a or 28a-f show r must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE 21208 items · death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NATHAN BLAIK **EVA** UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH KAHN / DAUGHTER 3616 VEAZEY STREET, NW, WASHINGTON, DC 20008 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 08/09/2011 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ FAILURE TO THRIVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** END STAGE DEMENTIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying due to for as a consequence of Exami the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 use as 1 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBELLAR INFARCTION 1 Yes 2 X No 3 Probably 4 Unknown Division of Vital Records, Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed?

1 Yes 2 X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, 1 ☐ Yes 2 🗓 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 X Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death laforest I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31 Physician/ July James 20 1 1 11:25 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Bowie Larkin Chase Nursing & Restorative Ctr . Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days June 3, 1 M 2 X F Months Hours Min Year 921 Maryland 90 220-18-7296 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits at 10a. State 10h Counts 10c. City, Town or Location the Maryland Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 No MD Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1205 Heritage Hill Dr. 20774 USA or items 23a Funeral with within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify. "natural", 3 Wildowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore City social worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Smith pe Robert Amos permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Heritage Hills Dr; Upper Marlboro, MD 20774 Jacqueline F. Brown - daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Othe (Specify) Ronal Sce Licen Virector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ongestive disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No been signed by the should be detached g Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has b page 2 s performed? Yes 2 No 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No 1 🗌 Yes ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide within 24 hours after deatl To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and Toe of certifier D45660 Bocie ath (Item 23a) (Type, Print) ss of person who completed cause

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner mm 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 65 yrs. 8. Date of Birth Social Security **Funeral** New York July 19 277-42-8608 1 🗓 M 2 🗆 F Months Hours 1946 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 ☐ No Columbia Howard Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral items 23a USA 21045 9467 Macomb Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 X Married Yes 2 X No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Loretto Lang Page 1 and 2 should be Thomas J. Leeds, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9467 Macomb Lane, Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type, Print) Patrice Bourgeois - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 08/10/2011 Laurel, Maryland Baltimore Wash. Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signa ure of Road, Columbia, Maryland 21045 MO1283 555 Twin Knolls Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final) Physician/ 0515 disease or condition Medical resulting in death) Due to (or a a consequence of) **Examiner** HICANTIN Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) **Director:** After this certific d in by the funeral director, Certificate: To Be 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred iniury 1 Natural 5 \square Pending Investigation after death Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number dress of person who completed cause of death (Item 23a) (Type, Print) St Baltimore Ragn 32. Registrar's Day, Year)
1 1 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 20<u>11</u> **Physician** Evelvn Ade1e Maus August 8, 5:00 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 19, Baltimore Manorcare Nursing Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) 1 □ M 2 ⋤ F 92 1918 Kentúcky 280-01-2836 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madesil Eurice 2000. 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 ☐ Yes 2x No MD Catonsville Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21228 1514 Adamsview Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TXNo Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Firm 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Litton Moore Wallace ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1514 Adamsview Rd., Catonsville, MD 21228 (Daughter) Linda Knight 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 AOther (Specify) Entombment Loudon Park Cemetery 8/15/11 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part I- Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR DISEASE **Physician** ERTENSIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Box 68760, Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) o. 1 ☐ Yes 2 No 9 Unknown signed by the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2hemer's DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Do059107

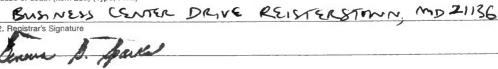
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State Registrar 31. Date filed (Month, Day, Year) 32. Regis

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Robert +4 Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 30 per DVR, G918, 8/11/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mangh Mangh 64 2011 Robert Kenneth McCarty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House / Montgomery Hospice Rockville 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** Days Hours Min 10-16-1952 1 X M 2 - F 551-96-8454 **Director** Usual Residence of Decedent 28a-f shov 10b. County aţ 10a. State 10c. City, Town or Location Director be notified MD Silver Spring Montgomery the 9 10e. Street and Number 10f. Zip Code ral", or items 23a Examiner must b Funeral 20906 3510 Forest Edge Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 after If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify Specify. Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) year Elementary/Seconday (0-12) Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked or ၉ Kenneth Foust McCarty Josephine Marie Pavusa 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Vickie McCarty / wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Ewing Church Cemetery 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 8/9/2011 4 Donation 5 Other (Specify) 21. Signature of Funer Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ⊬h, sician/ Non Squamous Cell Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I pe 24a. Was an autopsy

4c. County of Death Montgomery 9. Birthplace (State or Foreign California 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian Black, White, etc White 16b. Kind of Business Industry Construction 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 Forest Edge Drive Silver Spring MD, 20906 20c. Location - City or Town, State Ewing, NJ 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, MD 21227 Onset and Death Division of Vital Records, P.O. Box 68760 23d. Date of delivery Day Year Month 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 performed? death? Hospital or Attending Physician; The 2 🔀 No Yes 2 X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 \(\text{Yes} \) 2 \(\text{No} \) XNatural 5 Pending death. Investigation Director: / Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined after City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/4/2011 D37142 \mathcal{O} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montgomery Hospice 1355 Piccard Dr. Suite 100 Rockville, MD 20850 Coleman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 1 2011

7:00р м

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N& U Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month OS Physician/ 2011 Frances Machovec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE GOOD SAMARITAN N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🏻 F Davs Hours 0471871928 83 216-20-9369 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21206 5406 Plainfield Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker >0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hradsky Bessie John LU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5406 Plainfield Avenue, Baltimore, MD 21206 Bernard J. Machovec, Husband K Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Σ 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 08/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Leonard J. Ruck, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Alexandra 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. J Immediate Cause (Final INTRA CRANIAL d Physician/ disease or condition Medical resulting in death) X Due to (or as a consequence of) Examiner Σ Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No been signed by the atte should be detached for Month 5 Other (specify) Pregnant at time of death g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COAGULOPATHY, ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION, CORONARY ARTERY DISEASE autopsy has performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🗹 No 1 \sum Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this 28c. Injury at work?
1 ☐ Yes 2 ☐ No uneral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 🗌 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

25619

7-30 PM

MD

1 X Yes 2 No

Kus

Approximate Interval Between

Onset and Death

Day

29d. Date signed (Month, Day, Year)

08/06/2011

MD 21239

Year

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANDINI YADAV 5601 LOYLRAVEN BLUD BALTIMORE parkel

M.D.

DHMH 17 Rev 7/2009

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

000

RES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25620 Reg. NZ 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:10 P M 2. Date of Death Physician/ 9Day 2014ar Augerst Ruth С. Mann Medical 4a. Facility Name (if not institution, give street and number) County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Stella Maris Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 22 Yar 922 1 🗆 M 2 🛛 F Hours Min 216-14-8180 89 MaryTand Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Mary land Baltimore Sparks 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14205 Quail Creek Way Unit#303 21152 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: 3 X Widowed 4 Divorced Specify: White Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian Edward J. Moran Μ. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21221 Michael Mann / Son 1203 Engleberth Road Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney ValleyMem. Gdns. 1 X Burial 2 Cremation 3 Removal from State 8/12/2011 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ STAGE resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Que to for as a nonsequence offi cause. Enter Underlying Exami Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical $\mathcal{H}_{\mathcal{UTH}}\mathcal{M}_{\mathcal{NN}}$ Division of Vital Records, P.O. Box 68760 the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CEREBROVASCULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Hospital or Attending Physician: The L 24 hours after death. Funeral Director: After this certificate h 2 🗆 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 X No မ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify) 27. Manner of Death 1 Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ <u>AUGUS</u>T $10:20p^{M}$ 2011 PHYLLIS MASSIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE 3012 GWYNN FALLS PKWY If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** Hours Min. 1 🗆 M 2 👿 F Months Country)
MARYLAND Director 10-31-1923 220-16-8262 77 Usual Residence of Decedent show or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a or ner must be n Funeral 21216 USA 3012 GWYNN FALLS PKWY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Examiner Black, White, etc. or. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify. BLACK "natural", 3 😾 Widowed 4 🗌 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) -10-HOUSEKEEPING DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOHN JANEY ELIZABETH BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3012 GWYNN FALLS PKWY. BALTIMORE, MARYLAND 21216 PAMELA MASSIE (DAUGHTER) Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GARRISON FOREST VETERANS 8-15-2011 OWINGS MILLS, MARYLAN 4 Donation 5 Donation Other (Specify) 21. Signature of Ferral Service (consectionATHAN D. HIBNIR22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition SEPSIS Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner DECUBITU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine TOPR burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 the attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death ed by the 9 Unknown Division of Vital Records, P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò DIABETES 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed? Physician; The 2 🗌 No Yes 2 No ☐ Yes Be (25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 █ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number dov me 240867 migul 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SVITE 105 PIKESVIlle 21208 Mà 201 MILFURD MD SADOVNIK RD MIGUEL 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 CAROLYN AUGUST MAZER 05:40P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Davs Hours Country) 627 21 /1925 Director 217-20-4462 86 Yrs. MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 MONTROSE ROAD 20852 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married within 72 hours after δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 X Divorced Completed Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY LAW ENFORCEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic ev SOLOMON BUCKANTZ HILDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN MAZER/SON 6604 QUAKER RIDGE ROAD, ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 08/10/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complicity ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one is use on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ROKE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or illijury Due to (or as a consequence of) anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 1 ☐ Yes ≥ t 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed EMEN TIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge. death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 0018084

DHMH 17 Rev 7/2009

State Registrar istrar's Signature

ZIMONTROSE RD.

outhor) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INESH

31. Date filed (Month, Day,

11-05086 Walter Nuckols Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Walter Nuckols	State of I	Maryland / Department o Ce <i>rtificate</i> o		ygiene Reg. No	2011	25623
Physician/	Decedent's Name (First, Middle,Last)			Date of Death Month Day		3. Time of Death 0758 hrs
Medical Examiner	Walter Wesley Nucl 4a. Facility Name (if not institution, give stre	cols	4b. City, Town, or Location of Death	July 8, 2011		
	3602 63rd Avenue	et and number)	Livettoville	' .	c. County of Death Prince (George's
Funeral	Social Security Number 6. Sex	7. Age (In yrs, last birthday)	If Under 1 Year If Under 24Hrs		M/DD/YYYY) 9. Birth	place (State or
Director	229-07-9455 1 ^X M	2 F 92 Yrs	Months Days Hours Min	11/11/19	Foreign Coul	
	Usual Residence of Decedent	<u> 92 </u>		111/11/19	1.6	VA
any.	10a. State 10b. County	10c. City, Town or Locat	on			10d. Inside City Limits
Aaryland 28a-f show 1 at once. ector	MD Prince Geo	rges Landover				1 X Yes 2 No
the Maryland a or 28a-f sh tified at once Director	10e. Street end Number		10f. Zip Code	10g. Ci	itizen of What Count	ry?
h the 13a or	3602 63rd Avenue		20785		ted State	
or items 23s.	11. Marital Status 1 Never Married 2 Married 3	Armed Forces? 1943 If Y	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto		 Race - America White, etc. 	an Indian, Black,
F. er dea	3 X Widowed 4 Divorced If Yes		Yes 2 No specify:		Specify: Whit	۵
urs after	or D	ates:	t's Usual Dccupation (Give kind of	work done 16b.	Kind of Business/In	
72 hou		College (1-4 or 5+)	ost of working life. DO NOT use reti	red)	Designation	
5-0036 ed within 72 hour de within 72 hour dysgiene. other than "natu the Medical Exau Completed	12	Salesm	an		Private	
Cotte Nagical	17. Father's Name (First, Middle, Last)			(First, Middle, Maide		
d be filtertal larked event,	Jesse Wynnfield Nuc		Mary Le.	lia Whitte		Zin Codo)
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Walter Bruce Nuckol		Michele Ct. Hu	•		Lip Gode)
9, N and 2 fealth item 2	20a. Method of Disposition	20b. Place of Dispos	ition (Name of cemetery,		. Location - City or T	own, State
DOC ages 1 nt of 1 ct. If	1 Bunial 2 Cremation 3 R	emoval from State crematory or oth	oln Cemetery 7/1	15/2011 B	rentwood.	MD
Baltimore, permit. Pages I an Department of Hea Important: If ite Important: other injury or other in	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ame and Address of Facility For			
Balt permit. Departu Import injury	Ruha thon #	340	l Bladensburg Ro	d. Brentw	ood, MD	
Physician	23a. Part I. Enter the disease, or complication		ne mode of dying, such as cardiac o	r respiratory arrest, sh	hock, or heart	Approximate Interval Between Onset and
y Medical Examiner	Immediate Cause (Final disease a. Hype	ertensive Atherosclerotic Cardi	ovascular Disease			Death
	or condition resulting in death) Due to	o (or as a consequence of):				
ē	Sequentially list conditions, if any, leading to immediate Due to	o (or as a consequence of):				
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execu	events resulting in death) Last d. UNPENDED UNPENDED W AMENDED4b-c, per me, g919, 9-1-11 sm 23d Date of delivery					
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687 ertific ding p e as th	23b. Was decedent pregnant in the past 12 months?		al death 3 Ectopic pregna	ancy	Month Da	y Year
b. Box 6876 the death certificate by the attending phy ched for use as the b Physician/M.	1 Yes 2 No 9 Unknown	Pregnant at time of death 5 Otl	ner (Specify)			
t the d		ibuting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to th	e cause of death?
ries that the signed by be detach				1 Yes 2	✔ No 3 Proba	bly 4 Unknown
Records, The law requires ficate has been sig				24a. Was an autopsy		psy findings available mpletion of cause of
e law				performed?		2 No
Vital Recysician: The lability certificate la director, page	25. Was case referred to medical		26.Place of Death (Check			
Vital ysician this certi directo	examiner? 1 ✓ Yes 2 No	al: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nursin	g Home 5 Resid	dence 6 🗸 Other:	Scene
27. Manner of Dogth 28c Date of Joints 29c Date of Joints 20c Date of						
ion trendi death. tor: the fi	1 V Natural 5 Pending 2 Accident Investigation		1 Yes 2 No			
The strain of th					I Route Number, City	
Divisopital or / bours after after y filled in E	4 Homicide	(Specify)				
To the Row within 24 h To the Fun completely	one) 2 Medical Examiner: On the	o the best of my knowledge, death occur ne basis of examination and/or investigat				
To the within 2 To the complet		manner stated.	29c. License number		. Date signed (Mont	
	Sant Quellell not)	O.C.M.E.	Jul	ly 9, 2011	
	30. Name and address of person who complete	eted cause of death (Item 23a)				
0		istant Medical Examiner 900	W. Baltimore Street, Baltin	more, MD 21223	3	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

8 / II / 2011 JH
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Per ab g919 9-6-11 vt
Reg. No. 25624 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** John Owen O'Brien 910 PM 44945+ 04 ,2011 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER DORLHESTER GENERAL HOSPITA AMBRIDGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) July 31, 1933 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Wisconsin 1 X M 2 T F 78 397-28-6315 Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hedical Examir or must be a coffined at 1 TYes 2 No Director Talbot Easton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21601 3 N. Thoroughgood Lane 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 □ No 1956 −
If Yes, Give
Year or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 salesperson sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Joseph O'Brien Marjorie Backes ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 N. Thoroughgood Lane; Easton, Maryland 21601 Mary E. O'Brien - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solice Licensee ROU 1 d S W 1/12 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part . Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. BRONCHIECTASIS Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.O. signed by the a be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' 1 □Yes 2 No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director; A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abul Foyez Arifuddowla 219 S.Washington Street Easton, Md 21601 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25625 Certificate of Death Reg. N. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 9, Day 2011 Year 11:05 P M Paul J. Oliver Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days Hours Oct. 28, 1925 1 XM 2 D F Virginia 215-24-0987 85 **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Baltimore Perry Hall 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8906 21236 Kilkenny Circle U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The moderant if item 27 is marked other than "natural", or item for any injury or other traumatic event, the Medical Examiner. Completed by 1 ☐ Never Married 2 🕅 Married 1 XYes 2 No If Yes, Give τπ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify 3 Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Plant Superintendent Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oliver Clarice Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Oliver / Son 859 Boxer Hill Rd. Cockeysville, Md. 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 Donation 5 Other (Specif 8/12/2011 Baltimore, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility 1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 🗌 Yes Yes Division of Vital funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident To the Hospital or Attending 5 Pending 2 🗌 No Investigation Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Limit is a cause of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Ce: Lying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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4105, Balkherr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	partment of Health and N ertificate of Death	, ,	ene g. n 201	1 25626	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Medic	al	4a. Facility Name (if not institution, give street and number)		Month AV Lvs		11 094 0 A-M	
and o	Examin	er	MERCY MEDICAL CENTER	BALTIMORE MD		4c. County o	f Death "	
	Funeral Director		5. Social Seculity Number 216-20-3522 Control of the control of		8. Date of Birth NOV • 8ay,	1924	9. Birthplace (State or Foreign Marry Land	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		·	10d. Inside City Limits	
	Maryla 18a-f s tiffied	Director	Md. Balti	more City			1X Yes 2 □ No	
	with the s 23a or 2 ust be no	Completed by Funeral Di	10e. Street and Number 2815 Hudson Street	10f. Zip Code 21224	10	Og. Citizen of Wh		
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🖁 No Specify:	ecify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc. White	
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland glene. grent than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Bus		
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Man	12 shoul lith and I 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Maryann Niedzwicki-Daughter 950	ailing Address (Street and Number or Rura				
re,	1 and of Heal item 2		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place) Aug			City or Town, State	
timo	Page Iment of tant: If jury or		4 □ Donation 5 □ Other (Specify) St.Sta	nislaus Cem 12	,2011 B			
Balt	permit. Page 1 a Department of I Important: If ite any fnjury or ot		21. Signature of Funeral Selvice Licensee	22. Name and Address of FacilitKac 2				
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tal	ician: 1 certifica ector, p		25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		AL NOT	2 103 2 24 110	
ζ	Physi r this c eral dir	e: 10	27. Manner of Death 28a. Date of injury 28b. Time	of land and	me 5 Residen 28d. Describe how			
ono	ending sath. or: Afte he fune	Medical Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury	work? M 1 Yes 2 No	Edd. Describe flow	injury decarred		
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_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 brous after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	To the within to the Comple	3	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type			114 0.42	1, 2011	
	Dr. David Vitberg, M.D. 301 St. Paul Street Baltimore, Md. 21202							
	Stat Registra		31. Date filed (Month, Day, Year) AUG 10 2011 AUG 10 2011	ale				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	1 - For State of Maryland / Department State Registrar Certificate			2011	25627
	,	1. Decedent's Name (First, Middle, Last)	OI Deatif	2. Date of Deat	th	3. Time of Death
Physiciar Medica	al .	Bruce Vincent Pronesti		August	8 2011	3:19p ⋈
Examine	r		own, or Location of Death Cascade	٦	4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8. Date of Birth	9. Bi	rthplace (State or Foreign
Director		314-54-6508	Days Hodrs Hvint	Nov 13,	1952	Indiana
/land f show ed at		10a. State 10b. County 10c. City, Town or Location	_			10d. Inside City Limits
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n with the is 23a o	Funeral Director	25224 Military Road	21719		10g. Citizen of What Co USA	ountry?
9 T.S	ò	Armed Forces? If Yes, specify 1 Never Married 2 Married 1 Yes 2 No	nt of Hispanic Origin? (Sp r Cuban, Mexican, Puerto X No S <i>pecify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examonce.	Completed	Flementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use re	done during most of wor	1	16b. Kind of Business Private	Industry
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imore Page 1 ar ment of H ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other	er place)		20c. Location - City of	
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asit ed	Examiner	Sequentially list nonctions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		, UK	124	_
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DIVISION tal or Attendir rs after death. al Director: Af ed in by the fu	ii certificate;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice	28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
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5		· lell m	7/7/49		9d. Date signed (Mont	
Ø	_	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William F. Harper, MD 180 Thomas Johnson	n, Ste 101,	Frederio	ck MD 2170	2
State Registrar		31. Date filed (Montif, Day, Year) AUG 11 2011 Sum A. Sark				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:15 PM 20/7 AYNE Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death 4b. Ci **Examiner** Baltimore osedale If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Security Number **Funeral** 1 X M 2 - F Hours Min. Director JARYIAND 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **Funeral Director** notified MD BALTIMORF ROSEDALE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō must be 23a 410 PATRICKS 21206 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. o, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) TRISTATE TRUCK DRIVER of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SPARWASSER LILLIAN EILSWORTH 19a. Informant's Name/Relationship (Type, Print) Com panicy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau ST. PATRICKS Rd. ROSEDALE, 410 MD 21206 of Health FAHNESTOCK JANICE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-2011 . Signature of Funeral Serv 21224 a as or comblications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest exist o y one cause on each line. 23a. Part 1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final undena Physician/ toration disease or condition Medical resulting in death) equence of) Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has birector, page 2 s autopsy performed death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 V No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Medical Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident hin 24 hours after death the Funeral Director. completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MKelle 2011 D006968 10 who completed cause of death (Item 23a) (Type, Print) Balto.

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1007 Essex 8. Date of Birth
(Month, Day, Year)
Dec. 30,1960 (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1 M 2 D F Days 218-84-189 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 9199 items ? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give "natural" Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than aumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Irans portation 1.9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Fe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date UDK permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) wood) 21. Signature of Funcial Socice License 18434 22. Name and Address of F SUP, PA Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. shock or heart failure. List only one cause on each line. Onset and D. ath Immediate Cause (Final CANCER UNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined completed filled in by 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 08-11-2011 D-51555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEIN AUNG, 9103 FRANKUN SOUA 30 UARE DRIVE, #2200, BALTIMORE ND 21237 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25630 Certificate of Death 1 Desedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:24AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Koaa imore 6. Sex 7. Age (In yrs, last birthday) If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 ► Months Hours Min. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No timare 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Yes, specify Cuban, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Blac If Yes, Give Year or Dates 3 ₩idowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, BO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) astor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnante) ပ္ 19a. Informan — ame/Relatio hip (Type, Pri Town, Şt**a**te, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State crimetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of Funeral Service Licensee mD 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between s t and Deat Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has I page 2 s autopsy perform this certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes ပ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Conflying Nursa Fractioner: The state of 29a. Certifier 29d. Date signed (Month, D 29b. Signature and title of certifier 29c. License number 106 no completed cause of death (Item 23a) (Type, Print) Name and address

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Resistrar's Signature

Physician/ Rae Medical **Examiner** Social Security Number **Funeral** Director 212-48-6284 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County death with the Maryland Director Maryland 10e. Street and Number Funeral 11. Marital Status þ within 72 hours after "natural", Completed the Medical Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Maryland 2121 Elementary/Seconday (0-12) Be မ 2011 Baltimore, 6 20a. Method of Disposition Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine -transit that the death certificate be executed Cause (Disease or linjury that initiated events and resulting in death) Last the burial attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No should be detached the been signed by þ Records, Completed LANA PARSONS has page 2 director, 25. Was case referred to medical of Vital Be examiner? 10 2 X No 1 🗌 Yes 27. Manner of Death Certificate: 1 X Natural Division Accident Suicide 4 Homicide

State of Maryland / Department of Health and Mental Hygiene For State Registrar 25631 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 9 10:47 AM August Parsons 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Lutherville 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Yea 8/2/1946 Country)
Maryland 1 M 2 XF 65 10d. Inside City Limits 10c. City, Town or Location 1 Tes 2 No Baltimore <u>Middle River</u> 10g. Citizen of What Country? 10f. Zip Code 13011 Oliverwood Road S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <u>Hospital</u> <u>Nurse Practioner</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luther Parsons Gladys Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Jung (Executor) <u>13603 Alliston Drive Baldwin, MD 21013</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 8/12/2011 Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral 1407 Old Eastern Av 5K Maryland 21221 23a. Part 1. Enter the disease, or complication that could the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Day Month Year Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No Hospital or Attending Physician: The law requires 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 24 hours after death.

Funeral Director: After this certificate 1 🗌 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 28b. Time of 28c. Injury at work? 1
Yes 28d. Describe how injury occurred 5 Pending 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. To the I only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 10 SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25632 State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 August 5 7:26 AM Thelma Lorraine Penn Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Care Timonium 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 920 Days Hours Min July 23 1 M 2 XX 91 219-18-0934 Maryland **Director** Usual Residence of Decedent 28a-f show 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XX No MD Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 409 Virginia Avenue Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 ☐ Married þ 1 Yes 2
If Yes, Give
Year or Dates 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 5, 2011 Frances E. Cuhn John W. Penn. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health as Important: If item 27 is any injury or act. Baltimore, MD 21236 Evelyn Bandell / Sister 7 Raylon Dr. Apt. J 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holy Redeemer Cem. Aug. 8,2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Rd, Baltimore, MD 21214 Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 phys the t attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\bar{X} \) No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 K No 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, page 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 2 🗶 No 1 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

a.m.

UGUST

THELMA PENN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

unella

JUNECIA WHITE, CRNP

within 2

only one)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25633 State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 3:00 A M Prachniak Theodore Aug Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FutureCare Northpoint Nursing Home <u>Baltimore</u> <u>Dundalk</u> 8. Date of Birth (Month, Day, Oct. 27 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Days Hours Country) 1 XM 2 - F Massachusetts Director 65 Oct. 1945 214-50-3090 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 XNo Dunda1k Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21222 1744 Burnham Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify: Specify. Year or Dates 1966-69 Completed 3 Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Steel Industry 12 Years Steelworker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Turbak Frederick Theodore Prachniak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1757 Drexel Road Dundalk Maryland Norman A. Prachniak (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Garrison Forest V.A.Cem. 8/12/2011 Owings Mills, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service License 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to hime date cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav 2 🗌 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 1 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 08-08-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTBAN BLVD -10+1 DASEEM 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

State Registrar Physician/ Medical **Examiner Funeral** Director 28a-f show 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director Maryland 10e. Street and Number Funeral <u></u> Baltimore, Maryland 21215-0036 Completed 2 should be filed within 72. It and Mental Hygiene. 7 is marked other than "r the

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1 and 2 s of Health item 27 other

permit. Page 1 a
Department of H
Important: If ite
any injury or ot

Physician/

Medical **Examiner**

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within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

physician

death certificate be Box 68760

Records, P.O.

Division of Vital

the Hospital or Attending Physician: The law requires that the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 9:32 P. 2011 Marie Anna Phillips August 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Pasadena Home Care Pasadena 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Country) Maryland Months Davs Min MOT1371923 87 1 M 2 X F 218 18 0902 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 Yes 2 X No Severn Anne Arundel 10g. Citizen of What Country? 10f. Zip Code U.S. 21144 7694 Mahogany Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Anna Ott ၉ John Voelker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severn, Maryland 21144 Beverly Buckner / Daughter 7694 Mahogany Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition MD State Veteran Cem. 08/09/2011 1 X Burial 2 Cremation 3 Removal from State Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comp shock, or heart failure. List lenotic Card oVas arlor Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 □ Yes 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 K Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year 29b. Signature and title aro. ause of death (Item 23a) (Type, Print) 708 Mountain Rd. Pasade State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25635 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vivian T. 2011 12:59 A^M Reimann August 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Harford Havre De Grace Harford Memorial Hospital 8. Date of Birth (Month, Day, Mar 13, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2**√** F Months Days Hours 75 Delaware 218-30-1623 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 🏖 No Maryland Harford Havre De Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 40 Robin Hood Drive, Lot #476 21078 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vaughn Tilghman Rachel E. Thomason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Reimann / Husband 40 Robin Hood Dr.Lot#476, Havre De Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/11/2011 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC Due to (or as a consequence of): SHOCK Sequentially list conditions Que to for as 9 gensequence off. If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 1 No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

death certificate be executed Records, The law requires of Vital Physician:

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filled in by the fu within 24 hours a completely

Physician

/Medical

Examiner

Director

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Physician/Medical

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Certification: To

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Funeral

Director

?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exercitant must be notified at

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau
once.

Physician /Medical

Examiner

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Khalid Puthawala, 501 S. Union Ave., Havre de Grace, Maryland 21078 32. Registrar's Signature Darka

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** James Edward Regulski Sr. 2011 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5950 Queen Anne Street Gwynn Oak Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Z **Funeral** Mary Land 218-52-3139 61 Director 1734 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Gwynn Oak Baltimore 1102/50/80 10e. Street and Number 10g. Citizen of What Country? 5950 Queen Anne Street 21207 USA by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 SYes 2 No 196
If Yes, Give
Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1966 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced 1968 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) S should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Food Industry 6. Regulati Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. George Regulski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once. James Edward Regulski,Jr., Son 5950 Queen Anne Street Gwynn Oak, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc.: 09/10/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Comos 23a. Part1. Enter the disease, r complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one see on each line. Immediate Cause (Final disease or condition resulting in death) Physician a Arteriosclerotic Cardiovesculas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): certificate be Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à Completed this certificate has page 2 autopsv perform 1 ☐Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Hospital: 2 □ No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 1866 Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP MILITELLO MD 6 TRIMBLEHILL CT. LYTHERDILLE, MD 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

25636

5:34 P M

10d. Inside City Limits

1 ☐ Yes 2√∑ No

²²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ∐ Yes 2 🖫 Ko Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) **ORIGINAL**

DHMH 17 Rev 1/2001

Registrar

AUG 1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roppelt, Sr. Dona1d 2011 5:48 P M Conrad Aug. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Dunda1k 7815 Lockwood Road If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** July 6, 1936 Days Hours 1 X M 2 □ F Maryland 75 Director 217-32-9590 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if fem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must be accessed. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Directo 1 🗆 Yes 2 ី No Dunda1k Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21222 United States 7815 Lockwood Road Armed Forces?

1 X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Peacetime 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Electrican Steel Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Roxie Tally Roppelt Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon Baker (Daughter) Dundalk, Maryland 1809 Merritt Blvd. 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sacred Ht. of Mary Cem. 8/13/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
Dundalk, Maryland Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failure. List only one cause on disease Immediate Cause (Final Onset and Death Physician/ yenes disease or condition resulting in death) Medical Due to (or as a con y quence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the bunal-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 Pregnant 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending
Investigation injury 1 Natural 2 Accident
3 Suicide
4 Homicide after death by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in 24 hours a Medical 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8-10-11 1)21022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602

√ DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25638 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 05 Year :03 AM Brian Lee 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Samaritan Haspital Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 M 2 D F Days Hours Yrs. **Director** 28a-f shov 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Baltimore 6 10e. Street and Number 10g, Citizen of What Country? or items 23a Waver 21239 USA 12. Was Decedent ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. "natural", Completed 3 Divorced Black Year or Dates. Marines 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) uld be filed within d Mental Hygiene. 12 Rehab HealthCare ech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Redd Bernard Daggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delora Green Wax Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date utik 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Albentown, PA preenwood Crematory 21. Signature of Fine al Service Licer 22. Name and Address of Jessup, PA 18434 1232 Midvalley Dr 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia. Physician/ MCA b Vein Dee disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** About I week Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown (cheanic Obstouctive Pulmonae 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cert 29c. License number 000 M.D. 2011 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLVD 5601 21254 BANSAL BALTIMORE AMIT 32. Registrar's Sig State Registrar

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DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5.48 PM Physician/ Mirriam Catherine Medical 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** icomico Hospice 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Mrs 8. Date of Birth **Funeral** Dec 29 Hours 1 □ M 2 🏻 F Maryland 86 Director 214-20-7304 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director Ocean City 1 Tes 2 No Md. Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21842**-**9332 9829 Winding Trail Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 🔀 Married ☐ Yes 2 🖎 No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Engravers 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked Knorr Baier Margaret John Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9829 Winding Trail Drive, Ocean City, Md. 2184 Kathleen Willett/Daughter Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 286 Place of Disposition (Name of Sacratic) Green at Control of Place) August 1 Burial 2 Cremation 3 Removal from State 11, 2011 Baltimore, Maryland Jesus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A 21. Signature of Funeral Sen Licens Md.21222 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) IME Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24 hours after death.

Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1
Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6

State Registrar

MDHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien for State Registrar 25640 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month SALIA SALLAYMATU 8:59PM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL PRINCE GEORGE'S LANHAN 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 CTEDDA 1 M 2 XF Days Min. Months Hours FREETOWN FREET Director 1972 Usual Residence of Deceden 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1
¥ Yes 2 □ No MD PRINCE GEORGE'S BOWIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4404 HATTIES PROGRESS DRIVE SIERRA LEONE. WA 20720 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married ð Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. BLACK 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NURSE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MOHAMED S. SALIA MTATTAATITEU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau FATU SALIA/SISTER 4404 HATTIES PROGRESS DRIVE BOWIE, MARYLAND 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Christ the King 4 ☐ Donation 5 ☐ Other (Specify) 8/27/11 Freetown, Sierra Leone College Cemetery J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3 kyan 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ SEPSI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or it that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 09/89 phys the b IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🖾 No Month Day Year ned by the at detached fo Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, BREAST 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury hours after death. 1 ☐ Yes 2 ☐ No the f Accident Investigation 6 Could not be Suicide completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State within 24 hours a To the Funeral I Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 67-28-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VER ROAD LAWHAM, MS 20106

State

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Please Type or Print in Black Indelible Ink. Epsure All Copies Are Legible. amend I tem# 1, per phy, g918 8-15-11 sm State of Maryland / Department of Health and Mental Hygiene 0 | | 25641 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 9 Day 201 Year Marlene Joan Stratmeyer Stratemeyer 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 6825 Campfield Rd. Baltimore Apt. 10E Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 1 M 2XX Months Days Min. oct.21,1 Hours Country) 79 Director 218-32-1763 Yrs. 931 Marvland Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TOWN. 1 Yes 2XXNo MD Baltimore Baltimore 10e. Street and Numbe 10g. Citizen of What Country? 6825 Campfield Rd. Apt. 21207 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. . 15 Armed Forces?
1 ☐ Yes XX No
If Yes, Give þ XXNever Married 2 - Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. "natural", White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professional Musician Music other traumatic event, Be 17. Father's Name (First, Middle, Last) 18: Mother's Name (First, Middle, Maiden Sumame) မ George Stratemeyer Olivia Nägel 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Hem 27 i George M. Schlesinger 27756 Leeward Drive, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1 Department of Important: If ii any Injury or or Moreland Memorial Park XSurial 2 ☐ Cremation 3 ☐ Removal from State Donation Other (Specify) 8/15/11 Baltimore, MD 21. Signature Funeral Cervice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Ph sician/ disease or condition resulting in death) wee Medical Due to (ow a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death Year 1 Yes 2 V the ☐ Unknown is been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate 1 ☐ Yes 2 🔀 No After this certification funeral director, I Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) nours after death.

neral Director: Aft
filled in by the fur Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours and to the Funeral I completed filled Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

29b. Signature

Lawrence

nd title of certifier

awtence

Quarry

ome

2700 Qu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Solomon

MD

29c. License number

Lake Drive

65

Pikesville,

21209

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25642 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July 10 ay 2011 Physician/ 1:20 Ам Jean E. Twist Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Summerville at Potomac Potomac If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Dec 9, 1920 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 💢 F Virginia 90 231-16-0461 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 Tes 2 No Rockville Montgomery 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 20850 118 Monroe St. #1405 ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) government personal assistant 27 is marked other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Helen Virginia Creecy Robert Page Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 Monroe St #1405; Rockville, MD 20850 Pat Twist – daughter item 2 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or of Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signolo - I Funeral Ser Director 655 W. Baltimore St; Baltimore, MD 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, Onset and Death Physician coronary atherosclerosis Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under in Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
g ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown adult fa<u>ilure to thrive</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

D37142

8/5/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoff Coleman 1355 Picard Dr. #100; Rockville, Maryland 20850 31. Date filed (Month)

State Registrar

Medical

29a. Certifier (Check

only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 00 Albert Malcolm Tucker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, 1 X M 2 □ F Hours New Jersev Director 1931 80 July 217-26-5474 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the house prometer of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f should protect the marked other than "natural", or items 23a or 28a-f should be notified at the model of the 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA Funeral 4700 Harford Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by altimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Tucker Millie Booker Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Beaumont Ave; Baltimore, MD 21239 19a. Informant's Name/Relationship (Type, Print) Eleanor Dansby - sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State Ronald S. Wate 22. Name and Address of Facility State Anatomy Board . Signat Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Securially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ 1 ☑ Inpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Box 68760 P.O. Division of Vital Records,

To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t

Certificate:

Medical

1 Natural

☐ Accident ☐ Suicide

4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifie

State Registrar

5 Pending

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 (2011) By 111 M.D. 40 Marylana Greneral Hospital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8/6/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25644 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 15:10 2011 Kosa 03 LUVALL 451 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex **Funeral** 1 □ M 2**X**□ F Months Days 70 217-38-4115 Maryland March 11, Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 x Yes 2 □ No Directo Maryland N/A <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3306 Rosekemp Avenue USA 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 🙀 Widowed 4 🗌 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Beauty Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Reich Thomas L. Boland မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracey Addison/ Friend 3304 Rosekemp Avenue Baltimore Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson Maryland 8/10/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitync 5305 Harford Road Baltimore Maryland 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory **Physician** day< disease or condition resulting in death) /Medical Due to (or as \ consequence o Chronic sustractive Pulmonory Disease Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 T Ectopic pregnancy 2 Fetal death Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 Tyes 2 No Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? ate has b page 2 s 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident eral Director: A filled in by the f Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 🛘 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

Eastern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

DHMH 17 Rev 1/2001 11595

29b. Signature and title of certifier

Matthew Finn

29c. License number

Res-060

29d. Date signed (Month, Day, Year)

tugust 03, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25645 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1046 AM 406 Dana Lang Tingler Medical Facility Name (if not institution, give street and number) or Location of Death County of De **Examiner** Health and 8. Date of Birth
(Month, Bay You If Under 24 Hrs 9. Birthplace (State or Foreign Sex Age (In yrs. last birthday) **Funeral** Year 1925 Hours Virginia 224-24-9719 85 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 Funeral items 23a USA 21040 309 Redbud Road 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 0 1 Never Married 2 Married þ Yes Sive Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White and Mental Hygiene. 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Manufacturer Rate Setter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental fitem 27 is marked 2 George Lanham Tingler Clara (nmn) Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 Pirates Court, Edgewood, Maryland 21040 Gary D. Tingler/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highview Memorial Gdn 8-12-2011 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Fallston, Maryland 4 Donation 5 Other (Specify) . Si / ati. / of Funera / ervice Ligensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Part 1. Enter the disease, or complic shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ 5 years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 ANO ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D34652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Scott Haswell

31. Date filed (Month, Day, Year)

NOLEK

2835 Smith Ave., Suite 203, Baltimore, MD 21209

		1 - State of Maryland State of Maryland	d / Depa <i>Cen</i>	irtment of F tificate of D	Health and N Death	Mental Hy	giene 0	11	25646
		Decedent's Name (First, Middle, Last)				2. Date of De	ath	Voor	3. Time of Death
Physici Medi		VINCENT W, TILLMAN				Month AUGVST	Day 6	Year 2011	03 53 AM
Exami		4a. Facility Name (if not institution, give street and number)			Location of Death			ty of Death	
	,	UNIVERSITY OF MAMUAND MEDICAL CENTE 5. Social Security Number 6. Sex 7. Age (In yrs. la		BA-LTIMO2		8, Date of Bir			
Funeral Director		5. Social Security Number 06. Sex 1 🕅 M 2 🗆 F 7. Age (In yrs. Ia	Yrs.	Months Days	Hours Min.	03727	/ 1957	Cou	place (State or Foreign htry) MD
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e Mar r 28a notifi	Öire	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Cou	
vith th	la la	108 Mosher Street		212	17		US		intu y :
nd Z1Z15-UU36 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S	. 13. V	Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-		ace - Ameri	
ffer d	by	1 ☐ Never Married 2 ☐ Married ☐ Yes 2 ☐ No If Yes, Give		Yes 2 X No	n, Mexican, Puerto	nican, etc.)	Speci	ack, White, fv. ${f Bl}$	ack
ours a stural	Completed by	3 ☐ Widowed 4X Divorced If Yes, Give Year or Dates. 15. Decedent's Education							al cata
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ING 21215-UU36 Filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Richard L. Tillman			18. Mother's Nan	ne <i>(First, Middl</i> e, tta Ha:	Maiden Surnai	me)	
Maryland should be file and Mental I is marked of raumatic eve	=								
0 - 0 -	1	19a. Informant's Name/Relationship (Type, Print) Floretta Harris Sister	II.		and Number or Rui				
t and theal item 2		20a. Method of Disposition 20b. P	lace of Dispos	sition (Name of			20c. Location	n - City or 1	own, State
Baltimor permit. Page 1: Department of H Important: If its any injury or ot		1 ☐ Burial 2X Cremation 3 ☐ Removal from State A ☐ Donation 5 ☐ Other (Specify)	enrance:	rcy crem	^(ce) 8/9	/11	Glen	Bur	nie MD
alti rmit. F partm porta y inju	1	21. Signature of Funeral Service Licensee							Fun Serv
a 88 E 8 8	1	Afformal Hilly	Tl	homasAl	lenPA 7	090 Ri	dge Rd	Han	over MD
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Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		EUKEMIA					Onset and Death
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ords, P.O. Box 68/60 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d							
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THe ficate		25. Was case referred to medical		06 D	lace of Death (Chec	1 🗆 Yes	2 K No		2 No
/Ita	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	Oth	er.	lome 5 🗆 Resi	idence 6 🗆 O	ther (Speci	5/)
DIVISION OF VITAI HECONGS, tal or Attending Physician: The law requires ts after death. al Director. Affer this certificate has been sig- ed in by the funeral director, page 2 should b		27. Manner of Death 28a. Date of injury	28b. Time of injury		y at		how injury occu		
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VISI or Att fter d frect	Certificate:	4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre)	eet, factory, office		28f. Location (City or To		nber or Run	al Route Number,
Division of Vital Records, F.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for		29a. Certifier 1 K Certifying Physician: To the best of my knowl	edge, death o	occured at the time	date and place	nd due to the co	ause(s) and mai	nner as stat	ted.
e Hos n 24 h e Fun	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	and/or invest	tigation, in my opinio	on, death occurred	at the time, date	and place, and	due to the c	ause(s) and manner stated.
To th within To th	2	29b. Signature and title of certifier		29c. Licens			29d. Date sign		
d		Dont All - M.P.		P2558	32		AUGUST	6,2011	
$\overline{}$		30. Name and address of person who completed cause of death (Item						•	
		DIENTE SVIFREDINI M.D. UNIVERSITY OF MAKE 31. Date filed (Month, Day, Year) 32. Registraris Signal AUG 1 2011	ure	EDICAL CENT	TER 22 SOUT	H GFEENE	ST. BALT	MAFE	MP 21210
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registraris Signat	arke	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 25647 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara S. Turner 2011 5:00 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death P.G. Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TF Months Hours (Month, Day, Year) Director **79** 372-34-9691 24-N.C Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified. P.G. Capitol Hgts. MD. 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6912 Canyon Drive 20743 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married ð 1 Yes 2 No If Yes, Give Year or Dates. 21215-0036 1 Yes 2 No Specify Completed 3 XWidowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ge 1 and 2 should be filed within the of Health and Mental Hygiene If item 27 is marked other the or other traumatic event, the DCPS School Teacher 4 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Andrew Turner, III/Son 6806 Storch Court, Landover, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem Park | 8/17/11 Landover, Md. f Funeral Service Licensee 21. Signatu Hackett's Funeral Chapel, Nac W. 814 Upshur Street, NW DC Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and that initiated events resulting in death) Last -burialthe attending physician Physician/Medical that the death certificate be the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Month 9 Unknown signed by th. be ארי Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician: The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has cu 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Marrier of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred Watural 5 Pending injury Accident 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) Demetriøs J. Catevenis, M.D. 3001 Hospital Dr. Cheverly, Md 20785

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1420 M 20 Year (TVERSKOY MARK Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai HUSPITER N/A 1 MO Social Security Number 6. Sex 1 M 2 G F If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min. 1072571932 78 Yrs. UKRAINE 216-31-4521 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director notified 1 ¥ Yes 2 □ No MD N/A BALTIMORE ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 21215 USA 3605 FORDS LANE, #311 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 K Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 'natural", 3 Widowed 4 Divorced WHITE Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nould be filed within 72 Ind Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ SPORTS SCIENCE **PROFESSOR** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ပ္ TVERSKOY YEVGENIYA FEDOROSKAYA ILYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. 2711 MOORES VALLEY DRIVE, BALTIMORE, MD 21209 VICTORIA POVERNI/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State ARLINGTON O'CHIZUK AMUNO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 08/10/2011 BALTIMORE, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mars 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death -Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner multi-engan Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury -transit certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 🗌 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed omboy to serve 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🗌 No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Certificate: or Attending 5 Pending Natural work' 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

SINOU

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #198 Per FH G918 8/25/2011 JH Amend #1 per med cept 6/119 State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 23a per dr.,g918,08/11/2011dhb Certificate of Death 25649 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Marian L. Wilson Day 02 Physician/ Year Marten -- t--- Witson AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Deat 4c **Examiner** 00/13 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yys. last birthday) 8. Date of Birth (Month, Day, Funeral Months Hours 1 □ M 2 🕱 F Days Yrs Director 06-01-1928 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Of. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Edgewater, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of E 9902 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic Obstructive Pulmonary Disease Approximate Interval Between Onset and Death Immediate Cause (Final natural Cause Complications Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine or any, leading to immediate cause. Enter Underlying Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe Yes 2 death? 2 🗌 No this certificate 1 🗌 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ALF 1 Yes 2 No ြု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending 1 Yes 2 🗌 No death. Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 CENT K086053 070611 Dettrine SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVERNA PARK MD 21146 DRIVE Zi3 New FORT Jane Schramek 31. Date filed (Month, Day, Year) Registrar's Signature State AUG Registrar

11-05972 S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ylvira Wood	1	State of Maryland / Department of Health and Mental Hygiene 2011 25650 -For State Certificate of Death
Physicia		legistrar 2. Date of Death 3. Time of Death
Andical Exami	ner	Month Day August 8, 2011 As Escilib Name (if not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		14.50-6685 1 M 2 XF GH Yrs. Months Days Hours Min. 12-24-1946 Country) MD
*oy		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location 10d, Inside City Limits
A		MD Paltimore 1 KYes 2 No
Aaryland 28a-f show	Director	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?
ith the M 23a or 2 ootified	힐	3931 Chesterfield Ave 21213 USA
0036 within 72 hours after death with the Maryland jeine. her thao "natural", or items 23a or 28a-f sho Medisal Examiner must be cotified at occe.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify:
2 hours af	g p	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
136 hin 72 h e. thao "n edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Security Adams is stable
-003 d withi rgiene, ther th	탉	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 ald be filed within 7 Mental Hygiene. marked other thao	BB.	Junius Edward Wood Annie S. Boyce
O 21 should nd Me is man	P	19a. Informant's Name/Relationship (Type, Pri 5 5 fer) 19b. Mailing Address (Street and Number or Rural Route Number, City or T State, Zip Code)
ore, MO 2 ges I and 2 shou of Health and I If item 27 is r	*	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Qate 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 Burial 2 Cremation 3 Removal from State Community or other place) 1 Population 5 Other State Bing State Bin
Baltimo permit. Page. Department o Importact: : injury or oth	1	21. Signature of Functor Service Licensee 22. Name and Address of Facility Cooks Terreral Service
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Returned Onset and
Physician Wedical		failure. List only one cause on each line. Death Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hyperensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause
nsi e d	Exal	events resulting in death) Last Due to (or as a consequence of):
be executed (sician and burial - transi	edical	UNPENDED AMENDED
Box 68760, e death certificate be the attending physici ed for use as the burnised for use as the burn	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
x 6876 n certificate ending phy use as the t	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
D.O. Box 6876 that the death certificate need by the attending phy detached for use as the	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?
P.O. s that tl gned by	<u>る</u>	1 Yes 2 No 3 Probably 4 Unknown
ords, P.C w requires that as been signed be	eted	24a. Was an autopsy findings available autopsy prior to completion of cause of
ecol ne law te has ige 2 sl	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Recicias: The scertificate rector, page	BeC	25. Was case referred to medical 26. Place of Death (Check only one) examiner? Light Check only one) Examiner Check only one Check on Check o
Division of Vital Records, P.O. rat or Attending Physiciae: The law requires that the safer death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	To E	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 0 Other Science
ion of tending Pheath. or: After the funeral	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year)
r Atter ter dea irector	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divis Hospital or A 24 hours after Fuceral Dire tely filled in b	Certification:	4 Homicide determined (Specify)
H 4 5 9		29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. August 9, 2011
10		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
IU	tate	2.2 Degistrar's Signatura
Regis		AUG 1 1 2011 Server B. Jacks
DHMH 17 Rev 1/ OCME 2006	2001	ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month WATSON R. THEODORE 149451 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **LANHAM** PRINCE GEORGE'S Examiner DOCTOR'S HOSPITAL 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F Months Days Mir SEPT 27 1940 WASHINGTON, DC 70 Yrs **Director** 577-54-3271 Usual Residence of Decedent 28a-f show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 X Yes 2 No PRINCE GEORGE'S COLLEGE PARK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6200 WESTCHESTER PARK DRIVE #704 20740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc ģ 1 X Never Married 2 Married Marýland 21215-0036 BLACK 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ BEATRICE WATSON THEODORE WATSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6200 WESTCHESTER PARK DRIVE #704 COLLEGE PK, MARYLAN EVONNE B. CLAYTON/FRIEND Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY: 8/8/2011 RIVERDALE, MARYLAND J. B. JENKINS FUNERAL HOME, INC. . Signature of Funeral Service 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last physician and Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atter in the past 12 months?
1 Yes 2 No Por Year Month Dav signed by the a To the Hospital or Attending Physician: The law requires that the 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signati certifi 29d. Date signed (Month. 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWHAM, MD 20706 ANNAPOLIS ROAD KEXFULD BABILAH 9470 H.O. 50178

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year

AUG 1 1 2011

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25652 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5^{Day}2011 Physician/ AUGUST ROBERT LEE WALLER 1:45A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCREST HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) 30244843157 **Funeral** Year) 2011 Days AUGUST 5 Hours 1 □ xM 2 □ F OHIO 302-48-3152 57 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State эегтіt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number 23a Funeral 5738 UTRECHT ROAD 21206 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: AFRICAN AMERICAN 1 ☐ Yes 2X No Specify: 3 Widowed 4X Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) ADMINISTRATIVE CLERK GOVERNMENT other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ WILLIE JORDAN WALLER JETTIE MAE TAYLOR of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE WALLER/BROTHER UTRECHT ROAD BALTIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 8/15/2011 RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. of Funeral Service Signat 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death signed by the a Unknown eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform death? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. work?
1 Yes 2 No injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3. only one nd title of certifier 29d. Date signed (Month, Day, Year) Signature 8615000 10 Political, snew Hall By 2014 9

State

Registrar

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		_	For State of Ma		partment of Health a ertificate of Death		1102 _{n.N}	25653
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		[4	2. Date of Death Month	Day Year	3. Time of Death
	Medic	al	Mary Wallas 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location o	August	10, 2011 4c. County of Death	4:10 P ^M
	Examin	er	Chapel Hill Nursing Ce:	nter	Randalls		Balti	1
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day,) Feb. 3,	g. Birth Cou	nplace (State or Foreign ntry)
	Director		220-30-2166 Usual Residence of Decedent	93 Yrs.		Feb. 3,	1918 [Pen	nsylvania
	land show dat	tor	10a. State 10b. County	10c. City, Town or I				10d. Inside City Limits
	Mary 28a-f	Director	MD Baltimore	Owing	s Mills		ng. Citizen of What Cou	1 Yes 2XXNo
	vith the 23a or st be r	ral	10e. Street and Number 4313 Flint Hill Dr. A	pt. 201	10f. Zip Code 2111			
	eath w	Funeral	11 Marital Status 12 Was Decedent Ev	ver in U.S. 13	B. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	14. Race - Amer Black, White	ican Indian,
36	within 72 hours after death with the Maryland gene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes XX If Yes, Give Year or Dates.	10	1 ☐ Yes XX No Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		nite
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Maryland	12 should be file lith and Mental h 27 is marked o r traumatic eve	1 9	19a. Informant's Name/Relationship (Type, Print)		illing Address (Street and Numbe			
	and 2 Health em 27 ther tr		Judith Wallas / Daughte		3 Flint Hill 1		Oc. Location - City or	
Baltimore,			1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 1 ☐ Other (Specify)	cemeterv_ci	rematory or other place)		•	
altir	permit. Page Department of Important: If any injury of once.		21. Signature of Tuy ral Septice Licensee	1 Cremat	aiths ory & Chapel 22. Name and Address of Facilit	Eckhardt F	uneral Ch	apel P.A.
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	Physician/ Medical		disease or condition resulting in death) Due to (or as a	a consequence of):	tian preum	N) at		1 hour
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	p it	Examiner	did y, leading to in modulate cause. Enter Underlying Cause (Disease or iinjury	consequence of				,
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3876	rtificat ling ph e as th		IF FEMALE: 23c. If yes, outcome	of pregnancy			OO d Date of do	lives.
Box 687	ath certifice attending p	Completed by Physician/M	in the past 12 months? 1 Live Birth Pregnant at	2 Fetal death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de	Day Year
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ecc	e has l	dwo				autops perform	y prior to death?	completion of cause of
al H	ian: Th	BeC	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)	100	
ξ	hysic this ce al direc	P		ent 2 ER/Outpa		ursing Home 5 Reside		cify)
n o	ding F th. After	cate	1 Natural 5 Pending (Month, Day 2 Accident Investigation	y, Year)		28d. Describe ho	w injury occurred	
Division of Vital Records,	Atten er deaf ector; by the	Certificate:	3 Suicido 6 Could not be		street, factory, office	28f. Location (Str City or Town	reet and Number or Ru State)	ral Route Number,
<u>≤</u>	ital or irs afte ral Dir							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one) 3 Certifying Nurse Practioner: To the	xamination and/or inv	vestigation, in my opinion, death o	occurred at the time, date an	d place, and due to the	cause(s) and manner stated.
	To the within To the comple	Σ	29b. Signature and title of certifier	225t St. 7tty hillowiday	29c. License number		9d. Date signed (Mont	
				\supset	0375	73	August	11,2011
· √			30. Name and address of person who completed cause of d	eath (Item 23a) (Type	e, Print) Smith Ave	Batture 1	10515 ON	4
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 130AM 201 04 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** COUNT HOWARD JMB Social Security Number r 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 🗆 M 2 🛣 F Months Hours Min. 10-26-1945 Pennsylvania **Director** 203-36-9626 65 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2x No Brookville MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n Funeral 20833 U.S.A. 3517 Brookepark Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or ite Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meang injury or other traumatic event, the Meang injury or other traumatic event, the Meangle event. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Smith Regina McConnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Weymer (Son) 23104 Timber Creek Lane Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash. Crematory 8-7-2011 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin KNolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician CANCE UNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

Director: After this certificate has d in by the funeral director, page 2 s autonsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide rpleted filled in by determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier D0064539 2011 AUG A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 CEDAR LANE, COLUMBIA, MD HNUMURU 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

			State of Maryland		rtment of H			giene Reg. N <mark>2</mark> 0	1 1	25655
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Mahlaa Wya H				2. Date of Dea Month	ath _	Year	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of De		4c. County	of Death	8 700 1 111
	LAdmin		Seasons Hospice N.W. Hospital			allsto			altim	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 7. Age (In yrs. last 85	t birthday) , Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		y, Year) 3,1926	9. Birthp Count Mar	place (State or Foreign try) yland
	d tow	L	Usual Residence of Decedent	Town or Loc	ation				1	0d. Inside City Limits
	Aarylan 8a-fst tified a	ecto	MD Baltimore	,01117-01-200		Dı	unda1k			1 🗌 Yes 2 ឺ No
	th the N 3a or 2 t be no	Funeral Director	10e. Street and Number 1937 Codd Avenue		10f. Zip Code	21222		10g. Citizen of		
	ems 2	nue	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rac	ed St ce - Americ	an Indian,
ဝ	after de l", or it camine	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Yes, specify Cubar Yes 2 XNo		erto Hican, etc.)	Specify:	ck, White, 6 :: W	etc. hite
ე-იივი	hours a	letec	3 ☑ Widowed 4 ☐ Divorced Year or Dates.	16a, Deced	ent's Usual Occupa	ation		16b. Kind of B	usiness Inc	dustry
7	than "	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	rind of work done done done done done done done done	unng most or v	vorking	Own	Home	
7 01	filed wil al Hygie I other vent, th	Be	7 Years 17. Father's Name (First, Middle, Last)	11003	SEMITE		Name (First, Middle,		e)	
ryland	uld be I Menta marked natic e	욘	John Krieger				e Regulsk		01.1.75.7	2(-)
, Mar	d 2 sho alth and 127 is r er traur		Diane Maushardt (Daughter)	19b. Mailin	G Address (Street a	. Du	Rural Route Numbe ndalk, Ma	ryland	2122	2
more,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State cen	netery, crem	sition (Name of natory or other place Cemetery	e) 8/	Date 12/2011	20c. Location Balti	-	own, State Maryland
Baltimor	permit. P Departm Importa any inju		21. Signature of Funeral Service Licensee	22 D 7	Name and Addres uda-Ruck 922 Wise	Funera	1 Home of undalk, M	Dundal arvland	k, In 212	1C.
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente						Approximate Interval Between Onset and Death
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	Examiner	L	Sequentially list conditions, b.						_	
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x 00/2	n certifi ending r use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of		Ectopic pregnanc	y			ate of deliv	
. Box	the att	Physician/Medical	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of det 9 ☐ Unknown	ath 5 🗆	Other (specify)			Mi	onth	Day Year
7. O.	ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause giv	en in Part I.			/	he cause of death?
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DIVISION	l or Atten after dea Director: I in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office	— W	28f. Location (City or To	Street and Numb wn, State)	per or Rura	l Route Number,
ר	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after cleath. within £4 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowler of the control of the best of my knowler only one) 3 Certifying Nurse Practioner: To the best of my knowler only one)	and/or invest	tigation, in my opinio	on, death occur	red at the time, date	and place, and di	ue to the ca	ause(s) and manner stated.
_	To the within To the comp	2	20h Cianatura and title of certifier A		29c License	number		20d Date signs	ad (Month	Day Year)
			30. Name and address of person who completed cause of death (Item 2 N S - Rajapakse, M D 2835 S		Print) -	0376	- '	0/	10/11	0.0
			N.S. Rajapakse, M.D 2835 S	mith	Av. 5-	205	Balti	more	110	21209
	Sta Registr		31. Date filed (Month, Day, Year) AUG 11 2011 32. teg-strar's Signatur	ba	red					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g918 8-11-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 9 bay 2011 8:50 PM™ Ju₁y Katherine Louise Wainwright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 901 Sue Grove Road Baltimore Essex Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 08-16-1969 Country) Missouri 1 M 2 TF Months Days Hours Director 218-88-3115 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21206 109 McCormick Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Henderson Richard Lee Wainwright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 McCormick Avenue Baltimore, Md. 21206 James Kenneth Eder (Stepfather) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 08-4-2011 Towson, Maryland Signature of Funeral Service License Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Avenue Dundalk, Dundalk 2122 Inc. Victor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final tarlure Physician/ disease or condition resulting in death) patic Medical Due to (or as a consumence of) Examiner 4 ears tepatitis Sequentially list conditions, Examine tany, leading to immediat cause. Enter Underlying Cause (Disease or iinjury Due to for as a cor sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Substance Years Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 4 Pregnant a Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Depression 2 000 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 21 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Life Partner
6 X Other (Specify) Residence 2 No Other: 4 Nursing Home 5 မ 1 Inpatient 2 tpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

State Registrar

29a, Certifier

(Check

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Richie

th, Day, Year)

9101

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D37049

Franklin Square Drive.

2011

Bastimore Wd 21237

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Williams Month Physician/ nthia August 3:32 a M 8th 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospita N/A Baltimore Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 Months Davs Hours (Month, Day Year) MARYLAND 70 **Director** 218-36-9334 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location notified at Director 1 X Yes 2 No GLEN BURNIE MD. ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Examiner must be Funeral 23a 21061 USA 6907 GLENN RIDGE CIRCLE items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc ò þ 1 XNever Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: "natural", BLACK Completed 3 Divorced 4 Divorced Year or Dates event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha GOVERNMENT BUDGET ANALYST Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ RAYMOND W. WILLIAMS ARNITA SPENCER permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRYSTAL ROBERTS (DAUGHTER) ARMS CHAPEL RD. REISTERSTOWN, MARYLAND 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY 8-13-2011 GLEN BURNIE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Lic HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ause (Final Immediate disseminated intravascular coagulation Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 8 days epsis Secuentics y list constitution if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) chain multiple myeloma 2 weeks The law requires that the death certificate be executed and trar Due to (or as a consequence of) physician a sthe burial-Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death P.O. 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Vunknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death

1 Yes 2 \sum No 24a. Was an has autopsy performed? page 2 certificate Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) eral Director: After th filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 🏻 Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural ...aiural ☐ Accident ☐ Suic 5 Pending 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hours after within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

. O.C

3001

32. Registrar's Signature

South

Sweet

21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onater

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State of Maryla	ınd / Depa	artment of Health	and M	1ental Hygie	ene	
		1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death		2. Date of Death	g. No	25658 3. Time of Death
Physicia Medic	al	Nellie Ann Ashlin 4a. Facility Name (if not institution, give street and number)		4b City Town or Location	n of Death	July 8,	2011	9:42A. M
Examin	er 	Laurel Regional Hospital		4b. City, Town, or Location Laurel				g George's
Funeral Director		577-36-8384 1 □ M 2X F 83	s. last birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. Min.	8. Date of Birth July 22, 1	.927 W	9. Birthplace (State or Foreign Vashington, DC
fand f show d at	tor		City, Town or Loc eltsvill					10d. Inside City Limits
he Mary or 28a-1 e notifie	Direc	10e. Street and Number	ELCSATI	10f. Zip Code		10	g. Citizen of Wh	1 ☐ Yes 2 No
th with t ns 23a must be	Funeral Director	6310 Muirkirk Road	i a Liai	20705	2110/0		United	l States
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Vese X No If Yes, Give Year or Dates.		Vas Decedent of Hispanic Of Yes, specify Cuban, Mexica		icity Yes or No- Rican, etc.)		- American Indian, , White, etc. White
n 72 hou an "nat Medica	mplei	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	lent's Usual Occupation kind of work done during mo O NOT use retired)	ost of worki	ing 1	6b. Kind of Busi	-
ed withir Hygiene other than int, the	Be Co	Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last)	Clei		ther's Name	e (First, Middle, Ma		one company
ild be file Mental sarked c	Tol	John A. Jones				Abell		<u>.</u>
d 2 shou alth and 1 27 is m er traum		Roy Alton Ashlin, Jrson	19b. Mailin 63 1 0	ng Address (Street and Numi Muirkirk Roa	ad Be	N Route Number, C Ltsville,	ity or Town, Sta Maryla	and 20705
Page 1 an ment of He tant: If item iury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispose cometery, cremedar Hi	sition (Name of matory or other place) Cemetery				city or Town, State 1, Maryland
permit. Depart Import any inj		21. Signature of Funeral Service Licensee	E Br	Nameland Address of Fact Onald V. Borg	wardt	Funeral	Home,	PA Maryland 2070'
		23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
Physician/ Medical Examiner		disease or condition resulting in death) a. Pneumonia Due to (or as a conse						
	ner	Sequentially list conditions, if any, leading to immediate b. Respirator Due to (or as a conse		ure				
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To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the E	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 23c. If yes, outcome of pregions of the pregnant at time of the pregnant	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
requires that the de been signed by the should be detached	y Phy	9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause given in Par	rt I.	23e. Did toba	acco use contrib	oute to the cause of death?
equires seen sigi								Probably 4X Unknown
The law rate has bage 2 sl	Completed	-				24a. Was an autopsy perform	pri ed? de	ere autopsy findings available ior to completion of cause of eath? Tes 21/2 No
certifica rector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Nonatient 2		26. Place of De	· · · · · · · · · · · · · · · · · · ·	(only one)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 Yes 2		me 5 Residen 28d. Describe how		
al or Atte		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At I building, etc. (Spec.		eet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
Hospita 24 hours Funera eted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my kno only one) 3 Certifying Nurse Practioner: To the best of	ion and/or invest	igation, in my opinion, death	occurred at	the time, date and	place, and due to	to the cause(s) and manner state
4 3000	Σ	29b. Signature and title of certifier	my knowledge, d	29c. License number	ate and place	29	d. Date signed ((Month, Day, Year)
15		30. Name and address of person who completed cause of death (Ite	em 23a) (Type, P	1000/2	246	, 2	July	22-2011
- Ct-ct		ZORAYDA LEE-LLA 31. Date filed (Month, Day, Year) 32 Registrar's Sigr	nature I	LRH 7300	Van	Dusen R	d. Lawr	(Month, Day, Year) 22-20//
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25660 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 24^{Day} 11:26A. M July 201^{Year} Bibi Fatima Hussain Ali Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Prince George's Cheverly Social Security Number 7. Age (In yrs. last birthday, 72 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 8. Date of Birth **Funeral** Days Hours 213-92-5662 1 M 2 X F June 30, 1939 Guyana Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Florida Orange Orlando 1 ☐ Yes 2 🕅 No De filed within 72 mousemental Hygiene.

Irked other than "natural", or items 23a or 28.

His event, the Medical Examiner must be no 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 837 Clifton Hills Street 32828-6645 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: If Yes, Give Indian 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the A ONCE. Sales Clerk Retail Clothing Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mohamed Hussain Amina Bee Ali Subhan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5517 Lake Ridge Terrace Bowie, Maryland 20720 Mohamed S. Shameem -son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD National Mem. Park 7/25/2011 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or a B that initiated events resulting in death) Last burial attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 conths?

1 Yes 2 No
9 Unknown o Month Year Dav the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? the Hospital or Attending Physician: The After this certificate 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes opatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al death. Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) 29c. License number

Registrar

DHMH 17 Rev 7/2009

30. Name and address of

31. Date filed (Month, Day, Year)

JUL 28 2011

Demetrios James Catevenis, M.D. PGH 3001 Hospital Drive Cheverly, Maryland 20785

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2011 25 raldine /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltimore The Johns Hopkins HOSPIta If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 21 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year 1 □ M 2 🖾 F Months 1940 North Carolina 224-50-6219 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h Counts 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, Ite Medical Examinar must be realisted at 1 XYes 2 ☐ No Director Portsmouth Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 23701 United States 112 Carol Lane Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private 5+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ludie Mangum Andrew Adams ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22192 13222 Barrister Place Woodbridge, VA Alice_A. Taylor - Sister 20c. Location - City or Town, State Pages 1 8 20b. Place of Disposition (Name of cemetery, crematory or other place) July 30, 20a. Method of Disposition Department of Important; If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake, Virginia 2011 4 ☐ Donation 5 ☐ Other (Specify) Roosevelt Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signatury of Fun-stal Service Licensee 4001 Benning Road NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 M No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 □ Yes icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Director; A
filled in by the fu death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

29b. Signature and title of

EIZ 32. Registrar's Signature Year) 31. Date filed (Month. Day. 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

29d. Date signed (Month, Day, Year)

600 North Wolfest, Baltimore MD, 21287

			1 - State of Ma Registrar		artment of Healt tificate of Deat		Hygiene Reg. No. 20	11 25662
	District.		Decedent's Name (First, Middle, Last)			2. Date of	Death	3. Time of Death
	Physicia Medic		NELLIE HOLLAND BARTLETT			JULY	24, 2011	Year 5:10 P M
	Examin	er	4a. Facility Name (if not institution, give street and number) WILLIAM HILL MANOR		4b. City, Town, or Locati EASTON	on of Death	4c. County	of Death BOT
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Un	der 24 Hrs. 8. Date of	Birth	9. Birthplace (State or Foreign
	Director		217-50-1012 1 □ M 2 🖫 F	83 Yrs.	Months Days Hou	rs Min. 10/18	71927	MARYLAND MARYLAND
	and show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits
	Maryla 28a-f s etified	Director	MD TALBOT	EASTON				1 👿 Yes 2 □ No
	th the	alD	10e. Street and Number		10f. Zip Code		10g. Citizen of	What Country?
	ath wi	Funeral	501 DUTCHMANS LANE 11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	21601 Vas Decedent of Hispanic	Origin? (Specify Yes or I	USA No- 14 Rac	ce - American Indian,
စ္တ	fter de , or it amine	þ	Armed Forces? 1 Never Married 2 X Married 1 Yes 2 X If Yes, Give	No	Yes, specify Cuban, Mex ☐ Yes 2 X No Specific No Spe		Blac	ck, White, etc.
21215-0036	ours a atural' cal Ex	Completed	3 Widowed 4 Divorced Year or Dates.		ent's Usual Occupation	ony.	Specify	***************************************
215	n 72 h an "na Media	ldu	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	(Give k	rind of work done during r NOT use retired)	most of working	160. Kind of B	tusiness Industry
21	ygiene ygiene her th	Be Co	12 5+		OL TEACHER			ARY SCHOOL
Maryland	be filed antal H ked ot c ever	To B	17. Father's Name (First, Middle, Last) IRWIN B. GORMAN			other's Name (First, Mide ELLIE HAMIL		е)
ary	hould and Ma is mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Nu	mber or Rural Route Nur	nber, City or Town, S	State, Zip Code)
	nd 2 s lealth a m 27 i		ELIZABETH HOLLAND, DAUGHTER	11622	SOMERSET A	VENUE, PRIN	CESS ANNE	2, MD 21853
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State	1	natory or other place)	Date 7 / 0.6 / 0.01.1	1	- City or Town, State
altin	nit. Pa artmei ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	22	E CREMATION Name and Address of Fa	noility		ISVILLE, MD
ä	Depar Impor any in		Brianna M. Ru	, I F	ELLOWS, HELD OO SOUTH HA	FENBEIN & N	EWNAM FUN ET. EASTO	ERAL HOME, P.A.
 س	Ph_sician/ Medical Examiner	iner	Due to (or as a superior and to the superior and the supe		CARCIN		, acces,	Approximate Interval Between Onset and Deat
09/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within \$4 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjlury that initiated events resulting in death) Last c. Due to (or as a	consequence of):				
). Box 687	the death certific by the attending ached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome c 1 ☐ Live Birth 3 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			ate of delivery onth Day Year
, P.O.	ss that igned be be det	by P	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause given in F			tribute to the cause of death?
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Ę.	Physic this ce al dire	은	1 ☐ Yes 2 📆 No Hospital:	ent 2 ER/Outpatien y 28b. Time of		Nursing Home 5 - F		
0 0	ding th. After a funer	cate	27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident Investigation	Year) 200. Time of injury	28c. Injury at work? M 1 \sum Yes 2	_	be how injury occurr	ed
Division of Vital Records,	al or Atter s after deas I Director d in by the	Certificate:	3 Suicide 6 Could not be	ry - At home, farm, stre . <i>(Specify)</i>	et, factory, office		on (Street and Numb Town, State)	per or Rural Route Number,
_	e Hospita 124 hours 5 Funeral leted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of received the control of the control one only one) 1 Certifying Nurse Practioner: To the basis of examiner:	amination and/or invest	igation, in my opinion, deat	th occurred at the time, da	ate and place, and du	ie to the cause(s) and manner stated.
	To th withir To the	2	29b. Signature and title of certific	JG MD	29c. License numb	er	29d. Date signe	d (Month, Day, Year)
	1		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, P	rint)	7	1 , - 0	5-2011 Somp. UD
(0+		31. Date filed (Month, Day, Year) 32. Registra		OMIN 6 DA	25 HUE 1	EDERAL	SB MA, MD
	Stat Registra		JUL 27 2011	was d.	bake			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar 25663 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Beulah Jean Gloria Julu 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner ZASTOY albot Memoria 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 1 F Months Days Hours (Month Day, Year) 38 Maryland 72 Director 219-36-6033 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1 ☐ Yes 2 No Caroline Denton Μđ 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral USA 21629 10649 River Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: Black "natural", Completed 3
Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Memorial Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ပ Smith Charles Scott Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 608, Denton, Maryland 21629 Marvin Beulah / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place; Denton, Maryland 07-30-11 Spring Grove Signature Funeral Service Licensee 22. Name and Address of FacilityBennie Smith Funeral Home , Easton, Maryland21601 Dover St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ HNOXIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year Pregnant at time of death has been signed by the e Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of tension 24a. Was an autopsy certificate ha performed Yes 2 death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 100 Other: မ 1 Yes 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 To the Funeral Director: completed filled in by the 24 hours

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29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 5. Washington St De Shield Dennis Registrar's Signature State **2**6 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

29a. Certifier (Check

only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 25664 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norma Lee Broadwater Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death WM. Regional Medical Center Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 5, 1928 9. Birthplace (State or Foreign 1 M 2 XF 217-54-6695 Months Days Hours West Virginia 83 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits MD Allegany Barton 1 Yes XX No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country?
United States 18603 Takoma Drive 21521 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify: white 1 ☐ Yes 2 X No Specify. Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housework Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Michaels Violet Fairchild 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 is Gary Broadwater/ son 18603 Takoma Drive, Barton, Maryland other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel Hill Cemetery 07/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Barton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 20 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysiciana CONCESTIVE Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a done-cuence of ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal uea. 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE LUNG CHRONIC Completed 1 Yes 2 No 3 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy After this certificate I performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Sinpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Accide
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours aft

To the Funeral Di

completed filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 Grother D26907 JULY 26 2011

State Registrar 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25665 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 10:45 X Hyman H. Bookbinder July Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Springhouse at Westwood Bethesda Montgomery 8. Date of Birth (Month, Day, March 9 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday **Funeral** Days Hours 1 🕅 M 2 🗆 F Months Director 95 1916 053-01-5875 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🔣 Yes 2 🗌 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6508 Kenhowe Drive 20817 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 2 No 1943 þ 1 Never Married 2 Married Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Washington Representative <u>American Jewish Committ</u>ee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk h and Mental | 7 is marked o Louis Bookbinder Rose Polger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ida Leivick/Executor 6508 Kenhowe Drive, Bethesda, Maryland 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/26/2011 National Crematory Falls Church, Virginia 22. Name and Address Demissansky-Goldberg Memorial Chapels. 1170 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee Magheenhall MOIS97 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 the IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Month Year Day Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 Yes 2 No Yes 2 X No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Tyes 2 **X** No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20367 July 21, 2011

DHMH 17 Rev 7/2009

State Registrar Joel Kalman, MD 1396 Piccard Drive, Rockville, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

JUL 28 2011

Date filed (

			For State of Maryland / De	·		_		05666
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Death	2. Date of De	Reg. No 20	25666
	Physicia		William Eugene Bilodeau			Month	Day 2011	3. Time of Death 5:20 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, c	or Location of Deat		4c. County of Dea	
	/		Holy Cross Hospital	Silver			Montgomer	
I	Funeral		5. Social Security Number 8. Sex 7. Age (In yrs. last birthda 215-60-7832 7. F 50 Yrs	Months Days		8. Date of Bir (Month, Da July	Vear Cr	rthplace (State or Foreign ountry)
	Director		215-60-7832 58 Yrs Usual Residence of Decedent			July 2	20, 1953 Was	hington, DC
	fand fshov	to	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	Mary 28a-1 otifie	irec	MD Prince George's Riverdal					1 X Yes 2 ☐ No
	ith the	ral	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	
	ems 2	Funeral Director	6307 51st Avenue	20737 13. Was Decedent of F	Hispanic Origin? (Sr	pecify Yes or No-		JSA erican Indian
တ္	ter de , or it	by F	1 ☐ Never Married 2 🔀 Married	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Black, Whit	
	tural"	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 Yes 2 🔀 No			Specify:	White
-6	72 ho n "na Aedic	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occup ive kind of work done e. DO NOT use retired)	during most of wor	king	16b. Kind of Business	Industry
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 or 5+) Root		<i>'</i>		Roofing	
g	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle,	Maiden Surname)	-
<u> </u>	should be file n and Mental I 7 is marked o raumatic eve	F	Arthur Bilodeau		Marcele	ne Sande	rs	
Maryland 21215-0036	12 shouth and 27 is r	7	1	- '			er, City or Town, State, Zi	p Code)
	and Hea em	0	20a. Method of Disposition 20b. Place of Di	7 51st Ave	1	Date Date	MD 20737 20c. Location - City or	r Town. State
E E	Page 1 nent of ant: If it ury or o		TE Barrar 2 El Grantation o El Transcration Grate	crematory or other place litan Crem	· ·		Alexandria	
Baltimore,	permit. Page Department of Important: If any injury or once.	1 3	21. Signature of Euneral Service Licensee	22. Name and Addre		.572011		imore Avenue
П	20 E # 9							le, MD 20781
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Ph, sician/ Medical		Immediate Cause (Final disease or condition resulting in death) Septic Shock Due to (or as a consequence of):					Onset and Death
	Examiner		Bacteremia					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):					
	cuted ind transit	Examiner	Cause (Disease or injury that initiated events End Stage Live	Disease				
	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
20/	physis the l	edical	d					
200	certifi ending use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1	o 🗆 =			23d. Date of de	alivery
POX	death he atte ed for	sici	1 Yes 2 No	5 Other (specify)	Су		Month	Day Year
л Э	at the d by the		g Unknown Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause di	iven in Part I	220 Did t	obacco use contribute to	a the saure of death?
s,	ires th signe d be c	d by	, , , , , , , , , , , , , , , , , , , ,	····,···,···,				Probably 4 🖾 Unknown
Vital Records,	v requ	Completed				24a. Was		utopsy findings available
éc	he lav te has age 2	Juo					rmed? death?	completion of cause of
<u>a</u>	ian: T intifica ctor, p	Bec	25. Was case referred to medical examiner?	26. P	lace of Death (Che	1 \(\text{Yes} \)	Z ZAJNOJ I L Ye	s 2 LINO
5	Physic this ce al dire	မ	1 Yes 2 No Hospital: 1 No Inpatient 2 ER/Outpa		4 ∐ Nursing F	lome 5 Resid	dence 6 Other (Spec	cify)
n 01	ding F h. After 1 funera	ate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injur	y work	k?	28d. Describe h	now injury occurred	
UNISION	Atten r deat ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm,		Yes 2 No	28f. Location (S	Street and Number or Ru	ural Route Number
2	tal or rs afte al Dire ed in t		building, etc. (Specify)			City or Tou		
	Hospi 4 hour uners	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	th occured at the time	e, date and place, a	ind due to the ca	use(s) and manner as st	ated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	ge, death occurred at the	ne time, date and pla	ace, and due to th	e cause(s) and manner as	s stated.
	F 3 F 8		I al the		5305	-	29d. Date signed (Mont $ m July~27$, $ m~20$	
	K		30. Name and address of person who completed cause of death (Item 23a) (Typ		3703		July 219 20	
	W		Dr. Nabila F. Khan, 1500 Forest Gler	Road, Si	lver Spri	ng, MD	20910	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | 25667 State
Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY 30,2011 Physician/ MARGUERITE BRUST 9:07A Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** Country) Maryland (Month, Day, April 18, Months 1 🗆 M 2 💢 F Director 93 219-20-2474 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1
▼ Yes 2 □ No Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21701 40 East South Street 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If Item 27 is marked other than any injury or other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Salesperson 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Lula Cook Harry Charles Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Apple Avenue, Frederick, Maryland 21701 Evelyn C. Payne / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 4. 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery: 2011 Frederick, Maryland Signature of Funeral Service Licens keenevandades Basiord PA Funeral Home. MO1473 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner 0 00 Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 3 ☐ Ectopic pregna5 ☐ Other (specify) Day Month ģ Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 🗆 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene 20

25668 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22^{Day} JULY 2019 ELIZABETH MOORE COPSEY 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3632 GLENEAGLES DRIVE SILVER SPRING MONTGOMERY Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. (Month, Day, Year) Country) 1 □ M 2 🔽 217-46-9017 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State must be notified at Director 28a-f 1 Yes 2 No MONTGOMERY MD SILVER SPRING 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3632 GLENEAGLES DRIVE 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Yes, Give Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ed other than RETAIL ASSOCIATE RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည JOSEPH COLLINSON MOORE EDNA CAROLYN DONAHOE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1 0 4 2 ALAN COPSEY / SON 9706 STARLING RD., ELLICOTT CITY, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 🗹 Burial 2 🗌 Cremation 3 🔲 Removal from State MONOCACY CEMETERY 07/27/201 4 Donation 5 Other (Specify) BEALLSVILLE, 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME BARNESVILLE MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 10 yrs. shock, or heart failure. List only one cause on each line. Immediate Cause (Final INSULIN DEPENDANT DIABETES Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ATHEROSCLEROTIC VASCULAR DISEASE yrs. Caque mally list sonditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): HYPERTENSION 10 yrs. Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) JULY 25-2011 D35792 aw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWAROOP RAO 50 W. EDMONSTON DR., ROCKVILLE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 nristian Malik /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) **Examiner** Chever If Under 1 Year rince George's

9. Birthplace (State or Foreign Country) Hospital Center George's 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Davs 1 M 2 □ F naryland **Director** NONE Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, "tu "hedical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number venue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use petired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be LNKNOWN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 19a. Informant's Name/Relationship (Type. Print) Avenue \$ item 27 i permit. Pages 1 are Department of Her Important: If Item any injury or othe Once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State $7/22/2011_{
m Beltsville}$, MD Chesapeake 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Latney's Funeral Home, Inc cc02783831 Georgia Ave. NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Dremateuritu disease or condition resulting in death) /Medical ue to (or as a consequence of Examiner premodure bis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial rans incompetent cer the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) s been signed by the s should be detached 19 2011 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown No. After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No page 2 director, Be Medical Certification: To 6 ☐ Other (Specify) funeral irv occurred and Number or Rural Route Number,

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: filled in by Hospital completely

a	The Other significant conditions	orthodaling to death but not receiving	in the directlying educ	g	1 □ Yes 2
					24a. Was an autopsy performed∕r 1 ∐Yes 2 N
25	. Was case referred to medical			26. Place of Deat	h (Check only one)
	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/0	Outpatient 3 DOA	Other: 4 \sum Nursing Ho	ome 5 Residence
27.	. Manner of Death 1 Natural 5 □ Pending Mccident investigatio	(Month, Day, Year)	o. Time of lnjury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, of	fice	28f. Location (Street a City or Town, Sta
29		nysician: To the best of my knowled			

(s) and manner as stated. nd place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 7.19.2011

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Covendolyn Tess DIOZ HYOHEVILLE LLD 20782 3321 Tolda MD 31. Date filed (Month, Day, Year)

State Registrar

D35452

amended line 14/8-2-2011-wchd/map

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011

	•	1 - For State State Registrar	or iviaryland		tificate of L			giene Reg. No	2011	25670
Physiciar Medica		1. Decedent's Name (First, Middle, Last) Martha Davis Coll	ick				2. Date of De Month	ath	y ZO Year	3. Time of Death
Examine		4a. Facility Name (if not institution, give street and nu Constal Hospice of			4b. City, Town, or Salis	Location of Dear			. County of Dea	
Funeral Director		5. Social Security Number 217–54–7331 6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Bir	thplace (State or Foreign untry) nnsylvania
yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		Town or Loc	ation			_		10d. Inside City Limits
he Mar or 28a	Dire	Maryland Wicomico 10e. Street and Number	Sali	isbury	10f. Zip Code			10a Cit	izen of What Co	1 X Yes 2 No
th with the ms 23a must by	Funeral Director	949 Gateway Street			21801		ļ		USA	
. F.E	ह्	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes G Year or [2 🔀 No ive		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛛 No		Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh.	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. Z' is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade complete: Elementary/Seconday (0-12) College 1	d) 1-4 or 5+)	(Give ki	ent's Usual Occupi ind of work done of NOT use retired) ekeeper	ation Juring most of wo	rking		ind of Business alth Ca	
Iryland 2	To Be	17. Father's Name (First, Middle, Last) Dennis B. Davis	·				me (First, Middle, Naomi Tr			
, Maryla nd 2 should be salth and Men n 27 is marke er traumatic		19a. Informant's Name/Relationship (Type, Print) Michael Deshields/son			g Address (Street a					o Code)
Baltimore, i permit. Page 1 and 2 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State 20b. Pla	ace of Dispos Park Park	ition (Name of ates o'Mernor	fal 7/3	Date 30/2011		cation - City or Lisbury	
Balt permit. Depart Import any inj		21. Signature of Funeral Service is see	FIG	22	Name and Address Stewart 321 West	Funeral Road	Home by Salis	Hol burv	loway f	Downey, P.A. 801
Physician/		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	LIGNAN	Do not enter	the mode of dying	g, such as cardiad	c or respiratory arr	est,		Approximate Interval Between Onset and Death
Examiner	<u>.</u>	Sequentially list conditions.	(or as a conseque							
executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	(or as a conseque							
		resulting in death) Last Due to	(or as a conseque	ence of):						
ocrificate the ding physise as the	/Me	IF FEMALE:	itcome of pregnance							
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	in the past 12 menths?	Birth 2 Fetal egnant at time of de	death 3 🗌	Ectopic pregnanc Other (specify)	y 		2	23d. Date of de Month	ivery Day Year
dS, P.O. quires that the signed by all do detact	≥	Part II. Other significant conditions contributing to	death but not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did to		1	the cause of death?
VICAL MECONGS, ysician: The law requires s certificate has been sig	Completed			_			24a. Was a autop perfor		prior to death?	topsy findings available completion of cause of
sician: certific rector,	ng ng	25. Was case referred to medical examiner? 1 Yes Hospital:			Otho	ce of Death (Che	ck only one)			1/
ing Phys frer this uneral di	ate: 10	27. Manner of Death 28a. Date	Inpatient 2 E of injury 2 oth, Day, Year)	R/Outpatient 8b. Time of injury	3 DOA 28c, Injury	4 ☐ Nursing F at	dome 5 Resid			HOSP142
INISION OI al or Attending Pi s after death. Il Director: After the	Certificate	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place	e of Injury - At homing, etc. (Specify)	ne, farm, stree		Yes 2 No	28f. Location (S City or Tow		Number or Ru	al Route Number,
ospital o	<u>.</u>	29a. Certifier Certifying Physician: To the	pest of my knowled	dge, death oc	cured at the time,	date and place, a	and due to the cau	ise(s) and	d manner as sta	ted.
To the Havithin 24 to the Figure 10 the Figu		(Check 2 Medical Examiner: On the ba only one) Certifying Nurse Practioner: 29b. Signature and title of certifier	To the best of my k	knowledge, de	eath occurred at the	time, date and pla	ace, and due to the	cause(s)	and due to the of and manner as e signed (Month	stated.
F > F 0		1				05741		0	7/22	12011
3TE		30. Name and address of person who completed cau	se of death (Item 2	3a) (Type, Pri	3 SALI	SBURY	wo	2/5	202	
State Registrar			Registrar's Signatur	de	Ke					

Racka Collick

		-	For State Registrar	State of Mar	ryland / Depa <i>Cel</i>	artment of H tificate of D	eaith and iv eath		Reg. No.		25671
	Division	,	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	th	Year	3. Time of Death
	Physicia Medic		Tommy James Cl					July		011	11:35 A
	Examin	er	4a. Facility Name (if not institution, give Berlin Nursing	,		4b. City, Town, or Berin	Location of Death		4c. County		1
- Carlo	Funeral		5. Social Security Number 6. Se	7. Age (I	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	n		place (State or Foreign
	Director		425-408937	M 2 □ F	84 Yrs.	Months Days	Hours Will.	9/12/1	926	Cour	MS MS
	show show	or	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	cation					10d. Inside City Limits
	Maryla 28a-f	irect	MD Worcest	er	Berlin	_					1 🗆 Yes 2 🛣 No
	th the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of USA		intry?
	ath wi	Funeral Director	123 Branch St.	12. Was Decedent Eve	er in U.S. 13.	21811 Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-			can Indian,
9500-61212	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The and Mental Hygiene. The and Mental Hygiene. The and Merit and Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.	2	If Yes, specify Cubar 1 ☐ Yes 2🋣 No		Rican, etc.)		ck, White, \sim w h.	
<u>ئ</u> -	2 hou "natu edical	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	I (Give	dent's Usual Occupa kind of work done do	ition uring most of worki	ing	16b. Kind of E	Business In	ndustry
7.17	vithin viene.		Elementary/Seconday (0-12)	College (1-4 or 5+)		o NOT use retired) ntenance			Poult	ry	
ם ם	filed v al Hyg d othe event,) Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surnam	ne)	
Maryland	uld be I Ment narke natic e	욘	Robert Cloyd					Butle			
Σ Z	2 sho Ith and 27 is r traum		19a. Informant's Name/Relationship (Ty Gordon G. Cloyd			ng Address <i>(Street a</i> Branch					Code)
baltimore,	ge 1 and nt of Hea :: If item or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo		e) (e	Date 27-11	20c. Location	- City or T	
	permit. Page 1 a Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Lights)			2, Name and Addres					
ñ	Imp Per	7 13	> 10m 91	ac News		108 Will	iam St.	, Berl	in, MI	21	811
	Medical Examiner Shape in the privalent and street in the	al Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Due to (or as a c	consequence of):	ular (lorotic	accide Cardio	nt Nasa	ward	locer	Interval Between Onset and Death
	certificate be anding physic use as the bi	/Medical	IF FEMALE:	d					T		
Division of Vital Records, P.O. Box 68	sidan; The law requires that the death certific certificate has been signed by the attending I rector, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Cotopic pregnance Other (specify)	y 			ate of deli	very Day Year
S, T.	rres that tr signed by d be detad	by	Part II. Other significant conditions of	entributing to death but	not resulting in the	underlying cause giv	en in Part I.				the cause of death?
ecord	e law requi has been ge 2 shoul	Completed					_		rmed?	prior to co	opsy findings available ompletion of cause of
ř; m	an; Indition tifficate tor, pag	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Checi	1 \(\superstack Yes\)	2 X No	1 L Yes	2 🗆 No
X	hysici nis cer I direc	10 E	I L Yes 2 LA No	Hospital: 1	t 2 ER/Outpatie		r: 4 🔀 Nursing Ho	ome 5 Resid	dence 6 🗆 Ott	ner (Specii	fy)
ַם יי	ding P h. After t funera	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	Year) 28b. Time o injury	work	rat ? Yes 2 □ No	28d. Describe h	ow injury occur	red	
	To the Hospital or Attending Physician; The law requires that the death within 24 hours after death. Within 24 hours after death. Other Funeral Director. After this certificate has been signed by the attent completed filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		/ - At home, farm, str (Specify)		ies Z 🗆 No	28f. Location (S City or Tow		ber or Run	al Route Number,
ر <u>د</u>	e Hospita 24 hours e Funeral leted fillec	Medical	(Check 2 Medical Exami	sician: To the best of m ner: On the basis of exa se Practioner: To the be	mination and/or inves	stigation, in my opinio	n, death occurred a	t the time, date a	ind place, and di	ue to the c	ause(s) and manner stated.
_	To th withir To th∉ comp	2	29b. Signature and title of certifier	- 0	^	29c. License	number		29d. Date sign	ed (Month,	, Day, Year)
			Jenne	ewagn CK			135131		July	26,	2011
1	SA 54		30. Name and address of person who correctly Pennie Savage,				r, Berl:	in, MD	2181	1	
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 8 2	32 Pagistror							

State of Maryland / Department of Health and Mental Hygien ? for State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 Year Physician/ JULY 22. DAYHOFF ELIZABETH 7:35p ANNETTE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll **Examiner** Westminster Carroll Hospital Center . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months Mary Tand 579-38-3150 82 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director be notified Mount Airy 1 X Yes 2 No Maryland Carroll 10f. Zip Code 21771 ö 10e. Street and Number 10g. Citizen of What Country? 23a Funeral with Calliope Way 611 must United States items death \ 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. 0 by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Landscape Company the Bookkeeper other traumatic event, Be filed \ Department of Health and Mental H. Important If Them 27 is marked oth any injury or other traumation once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Ralph Thompson Majorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Calliope Way / Mount Airy, MD 21771 Carl W. Dayhoff / husband 20b. Place of Disposition (Name of Cem cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗌 Cremation 3 🗀 Removal from State Taylorsville Methodist 07/28/2011 Taylorsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, 21771 E. Ridgeville Blvd./Mount Airy, MD 1/2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Stuge Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 mor Month Day Year Pregnant at time of death 2 No ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be def Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Hospita 2 No Other: 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3

State Registrar 29b. Signature and title of certified

31. Date filed (Month

arroll

cause of death (Item 23a) (Type, Print)

D/23 62

Hospital Center, 200 Memoria

29d. Date signed (Month. Day, Year)

			101	partment of Health and N		
	Physicia		1. Decedent's Name (First, Middle, Last) Mary Elizabeth DeMu	ertificate of Death	2. Date of Death Month July 25	3. Time of Death 3:25 a M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 516 Highgate Terrace	4b. City, Town, or Location of Death Silver Spr	ing	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 578-30-7122 6. Sex 1 M 2 🖾 F 7. Age (In yrs. last birthda Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y 10/28)	9. Birthplace (State or Foreign Couptry) 1924 Washington, DC
	Maryland 28a-f shov otified at	irector	10a. State 10b. County 10c. City, Town or Maryland Montgomery	Silver Sp	ring	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	th with the ns 23a or must be n	Funeral Director	10e. Street and Number 516 Highgate Terrace	10f. Zip Code 20904		g. Citizen of What Country?
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myn injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🕱 Married ☐ Tyes 2 🛣 No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho giene. ier than "nat is, the Medica	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) Homemaker	sing 1	6b. Kind of Business Industry Own Home
Maryland	s should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Hebert George Barott			strander
	f and 2 sho f Health and item 27 is r other traun		Leon Emile DeMulder - Spouse 516 20a. Method of Disposition 20b. Place of Di	sposition (Name of	Silver Si	ity or Town, State, Zip Code) Oring, Maryland 20904 Dc. Location - City or Town, State
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	22. Name and Address of Facility Hir	res-Rinal	Rockville, Maryland Li Funeral Home, Inc. ilver Spring, MD 20904
moth	Physician/ Medical Examiner	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of):		or respiratory arrest	Approximate Interval Between Onser and Death Years
. Box 68760	Attending Physician: The law requires that the death certificate be executed ar death. The death sector, the first this certificate has been signed by the attending physician and exter. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial the page.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	requires that the dea been signed by the a should be detached f	2	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of death?
I Recor	ician: The law re certificate has be ector, page 2 sh	Completed	25. Was case referred to medical	26. Place of Death (Chec	24a. Was an autopsy perform	
of Vita	Physician:] rr this certifice eral director, p	e: To Be	examiner? 1	tient 3 DDA Other: 4 Nursing H		ce 6 ☐ Other (Specify)
Division of Vital Records,	al or Attending Phy s after death. I Director: After this d in by the funeral c	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined (Month, Day, Year) injui 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 Tyes 2 No		et and Number or Rural Route Number,
Ω	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dear only one) 3 Certifying Nurse Practioner: To the best of my knowledge, dear only one)	vestigation, in my opinion, death occurred a	at the time, date and	place, and due to the cause(s) and manner stated.
•	with with Som		29b. Signature and title of certifier	29c, License number D34032	29	d. Date signed (Month, Day, Year) July 26, 2011
			30. Name and address of person who completed cause of death (Item 23a) (Type Jeanne Asher, M.D., 3720 Farragut 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Avenue, Kensington	n, Maryla	nd 20895
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and		

or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Bey 7/2000

31. Date filed (Month, Day, Year) 28 2011

29b. Signature and title of certifier

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, Perry R. Weisman, MD 7300 Van Dusen Road Laure

D0067662

29d. Date signed (Month, Day, Year)

Laurel

July 20, 2011

			State of Maryland / Dep.				10
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. I		3
	Physicia	in/				Day 2011 3. Time of Death	- 1
	Medic Examin		Alice Dugan 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	-
	Examin	er	12305 Wight St.	Ocean City		Worcester	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Fore	eign
	Director		577-54-7388 1 □ M 2 🕱 70 Yrs.	Months Days Hours Min.	1 / 25 / 19	41 Washington	DC
	nd now at	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Lim	mits
	arylar a-fsl	ectc	MD Worcester Ocean			1 X Yes 2 □] No
	he M or 28 e noti	<u>=</u>	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	\neg
	with t	eral	12305 Wight St.	21842		USA	
	leath items ier mi	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,	
20	", or	by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2X No Specify:	, tiodin, otoly	Black, White, etc. Specify: white	
Ş	ours a ntural cal Ex	Completed	3 Wildowed 4 Las Divorced Year or Dates.	dent's Usual Occupation	101		
Ċ	72 h	μD	(Specify only highest grade completed) (Give	dent's Osdai Occupation kind of work done during most of worki IO NOT use retired)	ng 160	. Kind of Business Industry	
2	within giene. er tha the I		Elementary/Seconday (0-12) College (1-4 or 5+) Secre	,	บร	Government	
פ	filed within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maide		
<u>X</u>	ld be Ments arked artic e	P P	Harold John Althouse		Alice W		
Maryland 21215-0036	ge 1 and 2 should be file It of Health and Mental Is If item 27 is marked o or other traumatic eve		I to the second			or Town, State, Zip Code) 25401	1 1
∠ ∂	1 and 2 strength item 27 other tra			Ramblin Rose L			\dashv
baltimore,	ge 1 ant of h		1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State cemetery, cree	matory or other place)		Location - City or Town, State	
	permit. Pag Departmen Important: any injury once.			State Crem. 2. Name and Address of Facility Bu		llsboro, DE	-
g	permit. Page 1: Department of I Important: If it any injury or of			108 William St.			- 1
П			23a. Part 1 Enter the disease, or complications that caused the death. Do not ent shock, or Mart failure. List only one cause on each line.			Approximate	
1	Physician/		Immediate Cause (Final	Cardiovascular	Disease	Interval Between Onset and Death	
	Medical		disease or condition resulting in death) a. Due to (as a consequence of):	(C. 10 10 103 (D) (C)	VISCEST	10 yr	_
	Examiner	L	Sequentially list conditions b.				
	o it	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury				
	ecute and -trans	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
	be ex sician burial	dical Examiner					
20/	icate g physis the		d				
200	certif anding use a	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	Sotonia programav		23d. Date of delivery	Į.
ROX	death e atte	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year	
	t the by the	Ph	9 Unknown	and adula a source along in Dark I	00 5:11.1		0
7.	es tha igned be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the MIXed Connective Fissue	Ce & C		to use contribute to the cause of death? 2 □ No 3 □ Probably 4 🏿 Unkn	
g	requir	etec	Mixed Connective Tissue VI.	3 E * 3 C		24b. Were autopsy findings availa	
Records,	has k	Completed			24a. Was an autopsy performed	prior to completion of cause	of
ř	n: The fficate or, pae	e Co	25. Was case referred to medical	26. Place of Death (Check	performed 1 Yes 2 X	No 1 ☐ Yes 2 🗹 No	
VItal	s certi	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other:		6 ☐ Other (Specify)	
0	g Phy er this neral c		27. Manner of Death 28a. Date of injury 28b. Time o		28d. Describe how in		
o	endin sath. or: Aft he fur	fica	2 Accident Investigation	M 1 Yes 2 No			_
DIVISION	or Att fter de irecton n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
5	pital o		One Continue of M. Contitue Dhysisian To the heat of my knowledge doth	accuract at the time, date and place as	id due to the course(s)	and manner as stated	- 1
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inves only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	the time, date and pla	ace, and due to the cause(s) and manner	stated.
	To the vithin To the comp	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
			I de la	D24986 /	md.	7/27/11	
	,	ر	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	5 8	7	Robert J. Keilly mp 560	Print) Riverside Dr 610	1 Salish	Ury Md. 21801	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year)	barker		/	
			UVE / / /				

Amend Item 25 per me, 8918,08731/2011dnb Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For #23a part II, State of Maryland / Department of Health and Iviental Registrar #29a, #7, #8, per phys/f.h. Certificate of Death D.H., WCHD 25676 Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY Year Physician/ Robert Francis Doughty. 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO MEDICAL SALISBURY SULA SONOL 8. Date of Birth 2/8/38 Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. cial Security Numbe 7. Age (In yrs. last birthday) **Funeral** (Month /88/19/37 1 **X** M 2 □ F Months Min **Director** 214-34-7364 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location the Maryland Director notified 28a-f New Church 1 Yes 2 No VA Accomack 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō be ms 23a must be Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death with 23415 3164 Davis Rd., items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) M. Marital Status 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Specify. "natural" 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t; If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) **Flooring** and Mental Hygiene. Operations Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Susie Harmon Theodore Doughty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3164 Davis Rd., , New Church, VA 23415 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any Injury or other trau once. Aileen Doughty / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Tabernacle Baptist Cemetery Horntown, VA 7/30/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INFERIOR MYOCARDIAL ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 145 ONDRY AR Sequentiary list so runtor s, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last ARDIOGENIC Hospital or Attending Physician: The law requires that the death certificate be executed SHOCK APPROVED BY MEDICAL EXAMINE burial-tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy hed for t in the past 12 months? Year Month Day Pregnant at time of death Yes 2 L No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Generalised Bleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 After this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one, examiner? Other: မ 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ Daugherty Wendall Jay Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ISDUR If Under 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral 1 **X**M 2 □ F Hours Min. 01/23/1934 Maryland 214-32-5601 77 Yrs. Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a 21801 USA 512 Pine Bluff Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Sales Broker ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Cox Clifford Daugherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Pine Bluff Rd., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mildred Daugherty/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Sunnyridge Memorial Park 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/23/2011 Crisfield, MD . Signet e of Funeral Service Licensee Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MELANOWA Physician MACIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month should be detached for 5 Other (specify) Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Z No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \quad Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and 10058410 OTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARES

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 Medical ne (if not institution, gi **Examiner** 1419 8. Date of Birth
(Month, Day, Year)
July 25, **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 Months Hours Country) 578-66-4330 Director 1949 DC Usual Residence of Decedent · 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1105 Queen Street NE 20002 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 A Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔼 No **Black** Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Money Processer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Elkins Helen Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20017 Helen T. McCard - Mother 611 Edgewood Street NE #320 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ABurial 2 Cremation 3 Removal from State 6, August 2011 4 Donation 5 Other (Specify) Washington, DC Glenwood Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of). resulting in death) Last the burial Physician/Medical The law requires that the death certificate be attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? signe I be d 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficient Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Baltimore,

68760

Box

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 25680 = State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jun 27, □2011 Physician/ 8:40 Geraldine Mae Friend Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Garrett Friendsville 406 Milton O. Friend Rd. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** NOV . ZO Year 1921 West Virginia 1 🗆 M 2 🕱 F Months Days Director 89 214-42-0608 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County with the Maryland Director 1 Yes 2 X No Friendsville Garrett 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21531 USA 406 Milton O. Friend Rd. should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Effie Everly permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic e Frank Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Broadford Rd., Oakland, MD 21550 2645 Broadford Rd., Oakland, MD Francis L. Martin/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Blooming Rose Cemetery July 30, 2011 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signatur of Funeral pervice Licensee P.O. Box 275, Grantsville, MD 21536 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. 23a. Part 1. Enter the diseashock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed should b 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has by page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 **X**No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my option, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nu'se Pyriotioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. сопріете (Check 3 [within 2 To the I only one

State Registrar 29b. Signature and Mile of

A. Goralski,

JUL 29 2011

30. Name and add

Robert

Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

311 N. 4th St., Oakland, MD

29c. License number

D23979

29d. Date signed (Month, Day, Year)

7.28.1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar			Cer	tificate d	of Dea	ath		Reg. No.	2011	25681
	Physicia	m/	1. Decedent's Name (First, Midd.							2. Date of De	ath 2³3 ay	2011	3. Time of Death
	Medic		Concettina		·					07			1 TO:30 H
	Examin	er	4a. Facility Name (if not institution 17194 Hardy F	_	er)		4b. City, Tov		cation of Death			County of Death Howard	
	Funeral Director		5. Social Security Number 216-42-9412		Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months C		Under 24 Hrs. lours Min.	8. Date of Bir	th 9 1°1"	9. Birth Cou	place (State or Foreign ntry)
			Usual Residence of Decedent							, -, -, -			
	f sho	tor	10a. State 10b. County	/	10c. City	y, Town or Loc	ation						10d. Inside City Limits
	28a-	ire	MD Howar	rd	Mt.	Airy							1 ☐ Yes 2 No
:	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Inmportant: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 17194 Hardy Ro	oad			10f. Zip Co	771			10g. Citiz	zen of What Cou USA	intry?
	death item		11. Marital Status	12. Was Decede Armed Force		S. 13. V	/as Decedent Yes, specify	t of Hispa Cuban, M	nic Origin? (Spo Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Ameri Black, White	
0000-01717	ırs after ıral", or I Examii	ed by	1 ☐ Never Married 2 ☐ Ma 3X Widowed 4 ☐ Divorce		_	1	☐ Yes 🌂	□No S	Specify:		5	Specify: Whi	
ה ו	2 hou "natu edica	Completed		ent's Education nest grade completed)		(Give k	ent's Usual C ind of work o	lone durir	n ng most of work	ing	16b. Kir	nd of Business I	ndustry
7	thin 7	E O	Elementary/Seconday (0-12)	College (1-4	or 5+)		o NOT use rei naker	tired)			Own	Home	
ם ע	ed wi Hygie other ent, t	Be (17. Father's Name (First, Middle,	Last)		I HORIE	IBACL	18	3. Mother's Nam	e (First, Middle,			
yrand	l be til lental rked tic ev	၉	Giovanni C	ılotta				(Giusepp	ina Piz	zuto		
Mary	should and N is ma auma		19a. Informant's Name/Relations			19b. Mailin	g Address (S	treet and	Number or Run	al Route Numbe	er, City or T	Town, State, Zip	Code)
≥ :	lealth lealth im 27 her tr		Aurora Keffer/	laughter	1				ive, We				
2	age 1 a ent of h nt: If ite y or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		tate C	lace of Disposemetery, crem	natory or othe	r place)	ry 07/2	Date 6/2011		cation - City or 1	
parmore,	permit. P Departm Importal any injur		21 Signature of Juneral Service		DI	22	. Name and A	ddress o	f Facility Pr	itts Fu	neral	L Home 8	Chapel 21157
	E D = 6 0		23a. Fair 1. Enter the disease, of	or complications that cal	used the deat					-	_	ter, MD	Approximate
l n			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.					,	,		Interval Between Onset and Death
-	nysician/ Medical		disease or condition resulting in death)	a. Due to (or	va consequ	ien of):	ythim	ia				-	7 40
-	Examiner	,	0 4'-11-1'-4	Hym	Lamo	~							10 yrs
		ine	Sequentially list conditions, it any back grown and cause. Enter Underlying Cause (Disease or iinjury	Def to for	as a conside	ience of l							
-	and -trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Hym	as a consequ	ence of:	"-						10 yrs
3	cate be executed physician and the burial-transit		Trocating in double, East										
0/0	g phy g sthe	Medical	is service										
Š	tendin r use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Feta	l death 3	Ectopic pre	gnancy			2	23d. Date of deli	
ם כא	y the att	Physician/	1 Yes 2 No 9 Unknown	4 Pregna 9 Unkno	ant at time of o	death 5	Other (spec	ify)				Month	Day Year
	gned b	by P	Part II. Other significant condit			Mar.	1.	se given	in Part I.				the cause of death?
ς Σ	equires sen sig ould b	ted	Cardiae	Pacem at	me M	n gil	n			1 🗆	Yes 2		obably 4 Unknown
necolus,	has be	Completed								24a. Was auto		24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
	ficate ficate or, pag		25. Was case referred to medica					OG Diago	of Death (Chec	1 Tyes	2 K No		2 🗆 No
ב ב	ysicia s certi directo	To Be	examiner? 1 ☐ Yes 2 ☑No	Hospital:	patient 2 🗆	ER/Outpatien		Other:	,		dence 6	Other (Speci	f _V)
5	ng Finy ter thi neral c		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of		28b. Time of injury		Injury at work?		28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
5	leath. or: Af the fu	ifica		tigation			М	1 Yes	s 2 □ No				
INISIOII	after of Direct	Certificate:		28e. Place of	f Injury - At ho , etc. (Spec <i>ify</i>	me, farm, stre	et, factory, o	ffice		28f. Location (City or To		Number or Run	al Route Number,
-	To the hospital of Attending Priystolar: The law requires that the bearn certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical		of examination	and/or invest	igation, in my	opinion, o	death occurred a	t the time, date	and place,	and due to the c	ause(s) and manner stated.
	vithin or the	Σ	only one) 3 L Certifyir 29b. Signature and title of certific	ng Nurse Practioner: To er	the pest of my	y knowledge, c		d at the tin		ce, and due to th		and manner as sessioned (Month	
	WIL		1/11/		w.			D	15938			7/25/11	
	P		30. Name and address of person M - YWNYON GYL	who completed cause	of death (Item	23a) (Type, P	rint)	AD -	di loi	RANDA	USTO	ww m	d 21133
	Stat		31. Date filed (Month, Day, Year)	32. P	gistrar's Signat			,	y s manufer f				
	Registra	ar	1111 9	6 2011		M A	As Hed						

11-05375

atrick A Grotto		State of Maryland / Department of Health and Mer	-	_		25602
athor / Crotto		1-For State Certificate of Death	iliai i iyg			25682
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2.	Date of Death		3. Time of Death
Medical Exami				Month July 18, 20	Day Year 11	1704 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	n of Death		4c. County of Death	
		9286 Chenar Farm Road Easton			Talbot	
Funeral		Months Dave Hour	1.0		Foreig	
Director		327-42-0243 1X M 2 F 62 Yrs. Months Days Hour		08-22-1	L948 co	untry) IL
any	H	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
≜ ,,		MD TALBOT EASTON				1 Yes 2 No
Aaryland 28a-f show 1 at once.	용	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Cour	ntry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Director	9286 CHENAR FARM Road 21601			USA	
with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or				can Indian, Black,
death r iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexical 1 Yes 2 No	an, Puerto Rio	can, etc.)	White, etc.	
after	by F	3 Widowed 4 X Divorced If Yes, Giva Year 1 Yes 2 X No specify or Dates:			Specify: Whi	
hours natur Exam		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give during most of working life. DO NO.			16b. Kind of Business/I	ndustry
36 in 72 dical	ple	Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 SALESMAN			FINANCIAL	
15-0036 filed within 72 hours after Hygiene. ed other than "natural", e t, the Medical Examiner 1.	Completed	17. Father's Name (First, Middle, Last) 18.Mothe	er's Name (Fi	rst, Middle, Ma	aiden Surname)	
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	LEROY GROTTO IDA	CARDO	ONE		
221, hould then and Men is man	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	umber or Rura	al Route Numb	er, City or Town, State	, Zip Code)
MD d 2 sho lith and n 27 is	1	JASON P. GROTTO (SON) 2623 WEST RICE ST				
S 1 an of Hea		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Crematory or other place) Chesapeake Cremation		ate	20c. Location - City or	Town, State
IMOTE, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,	ı	4 Donation 5 Other Specify: Center	7/21/	2011	Stevensvil	le, MD
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	1	21. Agree and Address of Facilities of Fellows, Helie	nbein	& Newn	am Funeral	Home P.A.
		200 S. Harriso 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	n St.	Easto	n, MD 2160	Approximate Interval
Physician /Medical		failure. List only one cause on each line.	Carglac of Te	spiratory arres	it, shook, of fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Intraoral Shotgun Wound Due to (or as a consequence of):				20007
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last				
e executed ian and ial - transit		d				
e execian a	gigal	UNPENDED AMENDED				
ox 68760, eath certificate be a strending physicia for use as the burit	\$	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery	
certif	San	230. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectop 4 Pregnant at time of death 5 Other (Specify)	pic pregnancy	′	Month E	Day Year
Box 68760, e death certificate by the attending physic ed for use as the but	Physician/Med	1 Yes 2 No 9 Unknown				
0 - 0		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.		acco use contribute to	_
s, P.O. nires that th signed by d be detach	d b				2 ✓ No 3 Prob	
ords, w requir s been s should	Completed			24a. Was ar autops	y prior to c	topsy findings available completion of cause of
Reco	Ē			perform 1 Yes 2		es 2 No
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical 26. Place of Death examiner?				
of Vital Records, as Physician: The law require when this certificate has been signeral director, page 2 should be	P	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA			esidence 6 🗸 Other	Scene
n of \ding Ph. After tl funeral		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 1650 hrs 1 Yes 2 ▼	_ Su	a. Describe no Ibject shot	ow injury occurred self	
ivisior or Attend after death Director:	g	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, €		f Location (St	reet and Number or Ru	ral Route Number, City
Division pital or Attendio	Certification	Suicide Could not be determined (Specify) Deach		or Town, Sta		
Tospid 4 hour funer		29a. Certifier 1 Continue Physician: To the host of my knowledge, death occurred at the time date and o				
Divis To the Hospital or A within 24 hours after To the Funeral Dive	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.				
F S F S	Σ	29b. Signature and title of certifier 29c. License number	er		29d. Date signed (Moi	nth, Day, Year)
16		and o.c.m.e.			July 19, 2011	
ns I		30. Name and address of person who completed cause of death (Item 23a)				
3		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 2	1223		
91	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records. hours after death.
uneral Director; A death. within 24 hours a To the Funeral I completely

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 1 Natural
2 Accident 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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25683

2135 M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 □Yes 2No

30. Name and address State

14. Robert Goralski 31. Date filed (Month, Day, Year)

North Fourth St 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

311

Registrar

		-	_ State		artment of Hea tificate of Dea			201	1 25684
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th	3. Time of Death
	Physicia Medic			ble			July		011 2:35 A.M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of	
	Funeral			In yrs. last birthday)		Under 24 Hrs. 8	3. Date of Birth (Month, Day	1 9	9. Birthplace (State or Foreign Country)
	Director		199-09-5075	91 Yrs.	Months Days		ept. 5	, 1919 P	ennsýlvania
	and show l at	or		10c. City, Town or Loc	cation		.,		10d. Inside City Limits
	Maryli 28a-f otifiec	irect	Maryland Montgomery	Montgom	ery Village	e			1 ☐ Yes 2 🛣 No
	th the 3a or t be n	ral D	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country? States
	eath w	Funeral Director	8343 Marketree Circle 11. Marital Status 12. Was Decedent Ev	er in U.S. 13. V	20886 Was Decedent of Hispa	nic Origin? (Speci	fy Yes or No-	14. Race -	American Indian,
တ္တ	ifter de	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 N If Yes, Give	0	f Yes, specify Cuban, M		can, etc.)	Black, Specify:	White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. Ked othygiene. Ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	Completed	3 ★ Widowed 4 ☐ Divorced Year or Dates.	16a. Deced	dent's Usual Occupation	n		16b. Kind of Busin	White iness Industry
215	in 72 h e. han "n Medi	dmc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+	ilfo Di	kind of work done durin O NOT use retired)	ng most of working	7	_ 4	
2	d with tygien ther th nt, the	Be Co	2	Set	nior Clerk	. Mother's Name (Eirot Middle	Labora	tory
auc	be file ental h ked o ic evel	70 E	17. Father's Name (First, Middle, Last) Harry Deen		10	i. Mother's Name (Gertru		oninger
ary	hould and Mi s mar rumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	Number or Rural I	Route Number	; City or Town, Stat	te, Zip Code)
	of Tand 2 should be file of Health and Mental F fitem 27 is marked of rother traumatic ever		Susan Connors/Daughter					ville, Ma	ary1and 20853
Jore	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition 1 🛣 Burlal 2 □ Cremation 3 □ Removal from State	1	natory or other place)	Da			
Baltimore,	permit. Page Department (Important: II any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of FunerahService Licensee	Nerbeck M	lem Park 2. Name and Address of	7/27/ f Facility DeVo		Olney, N ral Home	Tal y Land
ñ	permit. Departr Importa any Inji		Merchan Alas	10	East Deer	Park Dr	., Gai	thersburg	g, MD. 20877
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	the death. Do not ente	er the mode of dying, s	uch as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
ani lan	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	nia				
	Examiner		Chron		uctive pu	Imenary	disea	se	
	n = 0	niner	cause. Enter Underlying	ou rsequence of):	0	U			1
	and and I-trans	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last Due to (or as a	consequence of):					
09	ficate be executed g physician and style burial-transit	edical	d						
9289	tificate ng phy e as the	Med	IF FEMALE:						
Box 6	ath cer attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live Birth 2	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		_	23d. Date Mont	of delivery th Day Year
Ö.	the deg	hysi	1 Yes 2 No 9 Unknown						
P.O.	s that gned to	ρ	Part II. Other significant conditions contributing to death bu	t not resulting in the u	underlying cause given	in Part I.			oute to the cause of death? 3 □ Probably 4 □ Unknown
rds	equire been si hould I	Completed					24a. Was		ere autopsy findings available
eco	e law r e has b ge 2 sl	dua					autor perfo	osy pri ormed? de	ior to completion of cause of eath?
a R	an: Th tifficate tor, pa	Be Co	25. Was case referred to medical		26. Place	of Death (Check	1 \(\text{Yes} \)	2 X No. 11	☐ Yes 2 ☐ No
Ĭ	hysici his ce al direc	은		nt 2 ER/Outpatie				dence 6 Other	
Division of Vital Records,	ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day,	Year) 28b. Time o injury	work?	: 21 s 2 □ No	8d. Describe h	now injury occurred	1
<u>Si0</u>	Atten er deat ector: by the	rţi		y - At home, farm, str			8f. Location (S		or Rural Route Number,
<u>≤</u> .	ital or irs afte ral Din		building, etc.						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and acompleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of many one) 2 Medical Examiner: On the basis of examiner on the basis of examiner on the basis of examiner.	amination and/or inves	stigation, in my opinion, o	death occurred at t	he time, date a	and place, and due t	to the cause(s) and manner stated.
	with a part of the state of the		29b. Signature and title of certifier		29c. License nu 75 49	umber		29d. Date signed	
) '		30. Name and address of person who completed cause of de	ath (Item 23a) (Type. I	Print) Bichhuoi		nh, M.I		3 2011
			30. Name and address of perside who completed cause of de	e, Olne	4 M.7	20832			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar	s Signature	New?				

			State of Maryland / Dep.			7011 / 25683
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death	Reg 2. Date of Death	g. No. 3. Time of Death
	Physicia		Henry W. Geter, II			27 ^{ay} 2011 12:55 A M
~ _*	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			1720 Bradmoore Drive	District Heights		Prince George's
	Funeral Director		5. Social Security Number 6. Sex 1 △ M 2 □ F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (2 yrs.)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 06/08/19	9. Birthplace (State or Foreign Washington, DC
			Usual Residence of Decedent		00/00/	
	/land f sho	햙	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	Mar. 28a- otifie	jre	MD Prince George's District			1 🔀 Yes 2 □ No
	ith the	ral	10e. Street and Number 1720 Bradmoore Drive	10f. Zip Code 20747		lg. Citizen of What Country?
	ems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
õ	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 No	f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: Black
ş	ours a	Completed	3 🗆 Widowed 4 🗀 Divorced Year or Dates.	dent's Usual Occupation	- 1	6b. Kind of Business Industry
21213-0030	an "na Medic	mple	(Specify only highest grade completed) (Give	kind of work done during most of work O NOT use retired)	ing '	66. Killa of business maustry
7	withir giene ner tha t, the		Elementary/Seconday (0-12) College (1-4 or 5+) Artic	hect	P	Private
yland	e filed ital Hy ed oth even	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam The 1 ma C	e (First, Middle, Ma	aiden Sumame)
ž	d Mer d Mer mark matic		Henry W. Geter 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	-	Nitu ar Town State 7 in Code
Mar	12 sho llth an 27 is rtrau		1.1	Bradmoore Drive D		
ē,	1 and of Hea item		20a, Method of Disposition 20b. Place of Dispo			0c. Location - City or Town, State
Ē	Page ment ant: If ury or		1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Removal from State Metropolia**	tan Crematory 07/	29/11 A	Alexandria, VA
Baitimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.			2. Name and Address of Facility Mar		
	20200	Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	308 Suitland Road		
e	h sician/		shock, or heart failure. List only one cause — each line. Immediate Cause (Final	Ad An		Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence). f):	Trung ors	ease	
	Examiner	<u>.</u>	Sequentially list conditions, b.	ı		
	sit sit	nine	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury)			
	kecute n and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	<u> </u>		
2	death certificate be executed ne attending physician and ed for use as the burial-transit	dical	d			
0/00	tificate ng phy as th	Med	IF FEMALE:			
o X	th cer ttendi	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of delivery Month Day Year
. DOX	v requires that the death certifics is been signed by the attending p should be detached for use as t	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)		
5	that th ned by e deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
as,	quires en sigi vuld be	ted k			1 🗆 Yes	s 2 XNo 3 Probably 4 Unknown
or vital Records,	aw rec las ber 2 sho	Completed			24a. Was an autopsy	prior to completion of cause of
E E	: The I cate h ; page				perform	
Iga	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpatient 2 FR/Outnatient	26. Place of Death (Chec		
>	y Physer this eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	f 28c. Injury at	ome 512 Residen 28d. Describe how	nce 6 Other (Specify) v injury occurred
00	ending eath. rr: Afte re fun	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
DIVISION	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	eet and Number or Rural Route Number, State)
5	spital ours a ours a leral E		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, ar	nd due to the cause	e(s) and manner as stated.
	n 24 h	Medical	(Check 2 Medical Example: On the basis of examination and/or inversionly one) 3 Certifying Nerse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date and	place, and due to the cause(s) and manner stated.
	Vithi Vomp	_	29b. Signature and title of Certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	600		1 1 sprans	D70102	C	7-28-2011
	THE		30. Name and addition of person who completed cause of death (Item 23a) (Type, Ivan Ngang Zama 9200 Basil Court Lar	Print) go, MD 20774		
٠	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	-		
	Registra		JUL 2 9 2011 Some & Jake			

State of Maryland / Department of Health and Mental Hygien

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of	lealth and Death		gien 2011	25686
	Physici /Medic		Decedent's Name (First, Middle, L Dorothy	ast) Elizabeth	Hutchis	son		2. Date of Dea Month 7 –	ath 20 ^{Day} 2011	3. Time of Death 8:45 A M
	Examir		4a. Facility Name (If not institution, g 9601 Chapel Roa	,			r Location of Dea	ath	4c. County of Dea	
	Funeral Director		Social Security Number 6.		(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		9. Bir (y. Year) 9. Bir 1918	rthplace (State or Foreign ountry)
100	0		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mes	8a-fsh	Director	Md. Tal	bot		Easto	n		40.00	1 □ Yes 2 No
dittier d	23a or 2	al Dir	10e. Street and Number 9601 Chapel Roa	d		10f. Zip Code 216	01		10g. Citizen of What Co	ountry?
5-0036	n 7z nous auer oberin with me maryiano n "natural", or items 23a or 28a-f show iedical Examber nast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Whi Wi Specify:	erican Indian, te, etc. hite
		Completed	15. Decedent's I (Specify only highest g	rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo d)	orking	16b. Kind of Business	/Industry
717	Hygiene. Kther than "		Elementary/Secondary (0-12)	College (1-4or 5+ -0-		Homemaker	•		Own Home	
		To Be	17. Father's Name (First, Middle, Las Emory Palm				Nanni e		Maiden Surname) ne	
Mary	alth and Menta 27 Is marked or traumatic ev		19a. Informant's Name/Relationship Palmer Hutchison			ng Address (Street B Chape l			er, City or Town, State, 21601	Zip Code)
baitimore,	perimic. Tages 1 and 2 should be perimic and the perimic of Health and Marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		20b. Place of Dispo cemetery, cre. Fairview	osition (Name of matory or other place Cemetery	7-2	Date 23-2011	20c. Location - City or Cordova, M	
Dall	Depart Import any Inj once.		21. Signature of Funeral Service Lice	ensee Hizowski C	. f. s P P	afteg nd &ddC .O. Box 5	strowski 18 St. N	i Funeral Michaels,	Home P.A. Md. 21663	
P	hysician	1/01	23a. Part 1. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that caused ty one cause on each line	the death. Do not en	ter the mode of dyin	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a	consequence of):		/			0
hatri	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
o/ou,	physician and the burlal-transit	al Exa	resulting in death) Last	Due to (or as a	consequence of):					
K 00/	ling phy e as the	Medical	IF FEMALE:	G		7				
OI VII MECOLOS, F.O. DOX 60/60, Physician: The law remittee that the clean continued	y the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 [☐ Ectopic pregnand ☐ Other (specify) _	ру 		23d. Date of de Month	elivery Day Year
ecords, P.	n signed b	þ	Part II. Other significant conditions	contributing to death but	t not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death? Probably 4 ☐ Unknown
	e has bee	Completed						24a. Was autop perfo	prior to rmed? prior to death?	
	ertificat ctor, pa	Be Co	25. Was case referred to medical examiner?					1 ☐ Yes eath (Check only o		s 2 No
Figure Physic	h. After this certificate has been signed by the funeral director, page 2 should be detached	<u>و</u>	1 Yes 2 → Vo 27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day,	nt 2 ER/Outpatie y (Year) 28b. Time of Injury	of 28c. Inju	4 LI Nursing		dence 6 Other (Sp now injury occurred	ecify)
DIVISI	within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	ho	ry - At home, farm, st . <i>(Specify)</i>			28f. Location (. City or To	Street and Number or F vn, State)	Rural Route Number,
Hospit	24 hour Funers etely fills	Medical (29a. Certifier 1 ertifying I (Check only one)	Physician: To the best o aminer: On the basis of and manner stat	examination and/or in	th occurred at the ti nvestigation, in my	ime, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
Tothe	within To the	Me	29b. Signature and title of certifier	100	1.10	29c. Licens			29d. Date signed (Mor	nth, Day, Year)
)	115		30. Name and address of person wh	Jelme	eath (Item 23a) (Type	Print)	5360	02	7/21,	///
	Ý		Carolyn Helmly,	M.D. 508 Id	dlewild Av		3 Easton	, Md. 21	601	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. registra	r's Signature	arked				

			State of Maryland / De	epartment of Health and M	ental Hygiene 2011 2568	37
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Dea	oth
	Physicia	n/	Flora Frances Hahn		July 24, 2011 11:12	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	LXGIIIII	<u>.</u>	Carroll Hospice Dove House	Westminster	Carroll	
T	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Fo. Wounth, Day, Year) 1936 W. Virgin	reign
	Director		218-32-8600 1 1 M 2 M 7 74 Yrs	6. <u> </u>	ug. 28, 1930 W. VIIgin	
	and show	ō	10a. State 10b. County 10c. City, Town o	Location	10d. Inside City Li	
	Maryl 28a-f otifie	Director	MD Carroll Keyma		1 □ Yes 2	No
	h the	al D	10e. Street and Number 825 Francis Scott Key Hwy.	10f. Zip Code 21757	10g. Citizen of What Country? U.S.A.	
	ith wii	Funeral		13. Was Decedent of Hispanic Origin? (Spec		
ပ္	er dez or ite miner	by F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto F	Black, White, etc. Specify: White	
000	ırs aft ural", II Exa	ted	3 🔀 Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		
15-(72 hoi 1 "nat Iedica	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of workir e. DO NOT use retired)	16b. Kind of Business Industry	
712	vithin jene. er thai	Co	Elementary/Seconday (0-12) College (1-4 or 5+)	le Supervisor	Book Publisher	
pu	filed val Hyg	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
yla	ge 1 and 2 should be filed within 72 hours after death with the Maryland the of Health and Mental Hygiene. If I frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	잍	Mahlon Welch		cie Lovejoy	
Mar	2 shouth and the shouth and the shouth the s				Route Number, City or Town, State, Zip Code) ey Hwy. Keymar, MD 217	757
e,	and Healt Healt tem 2		20a. Method of Disposition 20b. Place of D	isposition (Name of	Date 20c. Location - City or Town, State	
E O	age 1 ent of nt: If i		1 $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	crematory or other place) Church Cem. 7/28	/2011 Ladiesburg, MD	
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of h Important: If its any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Myers-Durboraw F		
<u>m</u>	99 E # 9		Equation R. Dunbapart	136 E. Baltimore	St. Taneytown, MD 21	787
			23a Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arrest, Approximate Interval Betwee # Onset and Dea	
	nysician/ ∮ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (, as a l-onsequence of)		Gravs	
	Examiner		Cl. Poetas	. 5	Week	5
		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Either Underlying	(market)		
	cuted	Examine	Cause (Disease or linjury that initiated events			
	cate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of)			
Box 68760	icate t g phys	Physician/Medical	d			
89	death certificate ne attending phy ed for use as the	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy	23d. Date of delivery	- 1
Bo	g e e	sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	5 Other (specify)	Month Day Year	
P.O.	that the des ned by the s e detached f	/ Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat	h?
S, F		d by			1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unit	known
ord	w require s been signal	plete			24a. Was an autopsy 24b. Were autopsy findings avait prior to completion of caus	ilable se of
of Vital Records,	The law requires sate has been sign page 2 should be	Completed			performed? death? 1 Yes 2 No 1 Yes 2 No	
ta	ician: The certificate rector, pag	a	25. Was case referred to medical examiner?	26. Place of Death (Check		70
ΨŽ	Attending Physician: ar death. ector: After this certific by the funeral director,	2	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outp 27. Manner of Death 28a. Date of injury 28b. Tir		me 5 Residence 6 Other (Specify) Hospic	
o uc	nding tth. : After e fune	cate	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) inji 2 ☐ Accident Investigation		, ,	
Division	r Atter ter deg rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Ď	oital o	Salc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath accuracy at the time, date and place, an	d due to the cause(s) and manner as stated	1
	Hosp 24 ho Fune leted f	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, de conly one) 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practioner: To the best of my knowledge, de conly one)	nvestigation, in my opinion, death occurred at	; the time, date and place, and due to the cause(s) and manne	er stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	MIL		· Withyle asp	00058137	7/25/11	
	4		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) St 307 Wastn	7/25/11 inster MO 21157	
	Sta	te	31. Date filed (Month, Day, Year) 32. 96gistrar's Signature	1	100	
	Registr		JUL 2 6 2011 Spens S.	Sacker		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-1 Per INF C921 II/21/2011 JH
State of Maryland / Department of Health and Mental Hygiene 25688 State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25, Physician/ Month July 2011 Elaine Herzbrun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac <u>Emeritus of Potomac Assisted Living</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day, Yea 06/11/192 New York Days Min. Hours 1 □ M 2 🗓 F Months Director 89 050-18-1144 Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director Boca Raton FLPalm Beach 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 33496-5147 18563 Breezy Palm Way 1215 Seven Locks Road Funeral Unit A USA 20854 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Rose Rill Robert Israel Lemberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13536 Bonnie Dale Dr. Gaithersburg, MD 20878 Robin Greger / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Grdns 07/27/2011 Olney, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc. MO1477 21. Signature of Funeral Service Licensee Kurt Blake 1170 Rockville Pike Rockville. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Yrs. <u>Alzheimers</u> disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence ut): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Chronic Kidney Disease Stage 4 Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X has After this certificate 1 Yes 2 No the Funeral Director: After this certific upleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted-4 □ Nursing Home 5 □ Residence 6 🖫 Other (Specify) Living Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2 🗌 No 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined vithin 24 hours.
To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and Atle of certif 29c. License number D21340 July 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wheaton, MD 20850 Raymond Bass, M.D. 3941 Ferrara Drive, 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

28 2011

			_ State	Department of Health and N Certificate of Death		2011 2568	9
			1. Decedent's Name (First, Middle, Last) DEBRA D. HARRISON	Certificate of Death	2. Date of Death	3. Time of Death	h
	Physicia Medic	al			July 18	year 05%	М
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	7	c. County of Death Pronce George	5
	Funeral		5. Social Security Number 6. Sex 7. Age (th yrs. last bin $577 - 86 - 4302$ 1 \square M 2 \searrow F 50	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9 / 9 / 1960	Birthplace (State or Fore	_
'v	Director		Usual Residence of Decedent		19/9/1900		
	iryland i-f sho ied at	Director		vn or Location		10d. Inside City Lim 1√z Yes 2 □	
	the Ma or 28a e notif	Dire	10e. Street and Number	INGTON 10f. Zip Code	10g. C	Citizen of What Country?	
	h with us 23a nust b	Funeral	823 11th St., N.E.	20002		TED STATES	
(0	or iten	by Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
003	urs afte ural", al Exar	ted b	3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1 Tes 2 No Specify:		Specify: BLACK	
15-(72 hor	Completed	(Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 	ring 16b. I	Kind of Business Industry	
212	within giene. Jer tha t, the I		Elementary/Seconday (0-12) College (1-4 or 5+)	SALES		RETAIL	_
and	oe filed antal Hy ced oth c even	To Be	17. Father's Name (First, Middle, Last) FERMAN BAYLOR		ne (First, Middle, Maiden TTE HARRI		
Maryland 21215-0036	hould I	1	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19	b. Mailing Address (Street and Number or Rur			\neg
S,	and 2 s Health em 27 ther tra			23 11th St., N.E. of Disposition (Name of	WASHINGT	ON DC 20002 Location - City or Town, State	\dashv
nor	age 1 age 1 art of H	1	1 Rurial 2 KCremation 3 Removal from State cemete	ery, crematory or other place)		ELTSVILLE, MD	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servina Licentsee	22. Name and Address of Facility 1425 MARYLAND A			000
			23a. Part 1. Enter the disease or complications that caused the death. Do			Approximate	
~	hysician/	, 1	shock, or heart failure. Wift only one cause on each line. Immediate Cause (Final disease or condition	entic Hyperterois	ve Heart	Drs Interval Between Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequence	e of):			
		iner	Sequentially list conditions, if any, leading to immediate b. Oue to (or as a consequence)	9 OT);-			\neg
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence	on).			
9	ate be executed hysician and the burial-transit	dical E	d.				
876	tificate ing phy e as the	Med	IF FEMALE:				-
Box 687	ath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 3			23d. Date of delivery Month Day Year	- 2
Ö.	the de by the	hysi	g Unknown				
, P.	v requires that the der sbeen signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting Mental Illwess	g in the underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4	
ords	v requir s been s should	Completed	Mental Illness DIAbetes		24a. Was an	24b. Were autopsy findings availat	able
Rec	sician: The law rectificate has k	Somp			autopsy performed? 1 \(\sum \) Yes 2 \(\sum \)		OI .
Division of Vital Records, P.O.	sician: certific rector,	Be	25. Was case referred to medical examiner? 1	26. Place of Death (Chec			-
of V	ig Physter this	te: To	27. Manner of Death 28a. Date of injury 28b.	Dutpatient 3 DOA 4 Nursing H Time of 28c. Injury at work?	ome 5 Residence 28d. Describe how inju		
ion	tendin death. tor: Aft the fur	Certificate:	Natural 5 Ferbing 2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	001 1 1 1 10 11 1	and Alicensham and Disease Deputs Alicensham	
Sivis	al or Ai s after I Direc	Cer	4 Homicide determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, street, factory, office	City or Town, Stat	and Number or Rural Route Number, te)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and	e, death occured at the time, date and place, a	nd due to the cause(s) a at the time, date and place	and manner as stated. ce, and due to the cause(s) and manner s	stated.
	o the l	Me	only one) 3 Certifying Nurse Practioner: To the best of my known 29b. Signature and title of certifier	29c. License number	29d. D	e(s) and manner as stated. Date signed (Month, Day, Year)	
	11		Ahadu Sharten Do	140053-92	7 J.	ly 20 2011	
	P		30. Name and address of person who completed cause of death (Item 23a)	tosaltal Drive	Leverli	Marsland	1
, <u>ş</u> .	Stat		31. Date filed (Month, Day, Year) 32. Registrat's Signature	7	7	7	
	Registra	ar	11 28 2011 Cenus p. 19				

			1 - State of Maryland / Department of State of Maryland / Certificate of Certificate of	Health and M Death		ena 011	25690
	Physicia		1. Decedent's Name (First, Middle, Last) Dorothy Lee Guy Hamilton		2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, 6	or Location of Death	(4c. County of Dea	th
	Funeral		PENINSULA REGIONAL MEAICAL CENTU 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth	Hiconyi O	thplace (State or Foreign
	Director		225-32-9657 1 M 2 X F 82 Yrs. Months Days Usual Residence of Decedent	Hours Min.	01/14/19	29 Vi	rginia
	f show	tor	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	r 28a-i notifie	Direc	Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code		10	g. Citizen of What C	1 Yes 2 No
	with the s 23a o	Funeral Director	409 Hayward Ave. 2182	6	10	USA	Sunity?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. It frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No 1f Yes, Sive Year or Dates.	Hispanic Origin? (Spec oan, Mexican, Puerto F o Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
15-0	72 hou n "natu Nedica	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.	during most of working	ng 16	6b. Kind of Business	Industry
212	within giene. ser tha t, the N		Elementary/Seconday (0-12) College (1-4 or 5+) Housewife	,		Domestic	
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Selby Claude Guy Sr.	18. Mother's Name Elizabet	(First, Middle, Man		
Mary	d 2 should be file alth and Mental back a 27 is marked our traumatic eve		19a. Informant's Name/Relationship (Type, Print) Billye H. Hudson/Daughter 19b. Mailing Address (Street 4980 Campgro	t and Number or Rural und Rd., E	Route Number, Co	ity or Town, State, Zi 21822	p Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heal Important: If item 3 any injury or other on		20a. Method of Disposition 1	MD 7/28/		Dc. Location - City of Hurlock,	
Ball	permit Depart Impor any in		Signature of Funeral Service Licensee 22. Name and Addr. Hollowa 501 Sno	ess of Facility y Funeral w Hill Rd.	Home Pro	fessional	Association
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line.				Approximate Interval Between
P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. C - duft Cruhe				Onset and Death
أتحمسه	Examiner		Due to (or as a consequence or):				
3	sit	Examiner	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	7			
	the burial-transit	Exa	Cause (Disease or iinjury that initiated events resulting in death) Last Cause (Disease or iinjury that initiated events resulting in death) Last Cause (Disease or iinjury that initiated events resulting in death) Last	unc			
09	ohysicia the bur	dical	d		· · · · · · · · · · · · · · · · · · ·		
. Box 687	the hin 24 hours after death. The law property atter death. The funds of by the attending physician and the funds of the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months?	ncy		23d. Date of de Month	elivery Day Year
P.O.	been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	jiven in Part I.			the cause of death?
rds	been si	eted			1 ☐ Yes 24a. Was an		robably 4 Nunknown utopsy findings available
Division of Vital Records,	cate has	Completed			autopsy performe	prior to death?	completion of cause of
/ital	tang russican, me th: After this certificate funeral director, pag	To Be	examiner?	Place of Death (Check		ce 6 Other (Spe	oifu)
ot	fter this		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury 1 Natural 5 Pending (Month, Day, Year) injury wo	ıry at 2	8d. Describe how		
Sion	after death. Director: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Yes 2 No	98f. Location (Stree	et and Number or Ru	ıral Route Number.
	rs after al Dire		4 Homicide determined building, etc. (Specify)		City or Town, S		,
	within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time of the properties	nion, death occurred at t	the time, date and p	place, and due to the	cause(s) and manner stated.
ķ	North COT		29b. Signature and title of certifier 29c. Licens		290	d. Date signed (Mont	
	7T		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	068222		(~ (1)
	SIC.		Raza AFZAL 100 E. Carroll St. Salisbu 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	my MD	2/80	l	
	Stat Registra	-	JUL 27 2011 June 1				

2/14/11 0 0030 Johnson, Elbert

			For State Registrar		State of M	laryland		irtment of h tificate of l		and Men		201	1 25	691
	Physicia Medic		1. Decedent's Nam ELBERT MC						vii.		Date of Death Month/19/	1 ^D ay Ye	ear	me of Death
	Examin		4a. Facility Name (if	not institution, give	street and number)			4b. City, Town, o	r Location	of Death		4c. County of	Death	
			Shady Gro			ge (In yrs. las	t hirthday)	Rockvil If Under 1 Year		r 24 Hrs. 8 r	Date of Birth	Montgom	_	tate or Foreign
	Funeral Director		710-09-7	365 1	X M 2 □ F	87		Months Days	Hours		9/01/2	par) M	. Birthplace (Si Country) D	
	show dat	tor	Usual Residence of 10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Insi	de City Limits
	Mary 28a-f otifie	irec	MD	Montgome	ry	Germa	ntown							Yes 2 No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Nur		- For			10f. Zip Code			10g	g. Citizen of Wha	at Country?	
	leath v items er mu	Fune	11. Marital Status	rryville	12. Was Decedent Armed Forces?		13. V	20874 Vas Decedent of H Yes, specify Cuba	lispanic Or	rigin? (Specify	Yes or No-	14. Race -	American India	an,
36	after o	d by	1 Never Man	ried 2 Married	1X Yes 2 If Yes, Give 1	No		Yes 2 XNo			.,, σ.σ.γ	Specify:	White, etc.	
2-00	hours natura lical E	olete		15. Decedent's E	ducation	T	16a. Deced	ent's Usual Occup	oation	at of working	16	Sb. Kind of Busin	lack ness Industry	······································
21215-0036	within 72 giene. ier than " i, the Mec	Completed by	Elementary/Sec	onday (0-12)	College (1-4 or	5+)	life. D	NOT use retired)			ialis⊭	NTH/G	overnme	-nt
d 2	ed wit Hygie other ent, th	Be C	12th 17. Father's Name				12010			her's Name (Fir		<u>_</u>		
Maryland	uld be file Mental narked c	욘	Elbert Mu	ırray Joh	nson, Sr.				Anni	e Laura	a McKea	mer		
Aan	should and h			ame/Relationship (7	**			g Address (Street						
	and 2 Health tem 2		Bernice \(\) 20a. Method of Dis		n/wite	20b. Pla	ace of Dispo	Berryvi ition (Name of	- 1	Date		oc. Location - Ci		ate
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.			☐ Cremation 3 ☐ 5 ☐ Other (Spera				munity (eneca,	MD	
3alti	permit. Departn Importa any inju		21. Signatur Fu	neral Service Licen	X	- 4	22	. Name and Addre	ss of Facil	lity Snowa	en Fune	ral Hom	e	20050
	FD = 46 Q		23a, Part 1, Enter	the disease, or con	Contigues that cause	ed the death		46 N. Wa			<u>-</u>		11:	ZUXOU ximate
	Physician/		shock, or hea Immediate Cause	23a. Part 1. Enter the disease, or complications that caused the ceath 00 not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition as a Previous Arrest Prev										al Between and Death
	Medical Examiner		resulting in death)	on F	Due to (or as	a conseque	ence of):	ineu	ACO V	Faile			1	
	LAAIIIIIei	er	Sequentially list co	onditions,	b. Due to for as	gest		Hear	+	taile	ire			
	p p b	Examiner	if any, leading to it cause. Enter Unde Cause (Disease or that initiated event	iinjury	A .	psis								
	cate be execute physician and sthe burial the	a EX	resulting in death)		Due to (or as	a conseque	ence of):	- Coli	11 -3			- C. Fasti		
68760	cate be physic	edical			ld	ceri	ente	~ Con	WIL	ayı	ract -	-ntecti	0 1	
.89	certific ending use as	M/m	IF FEMALE: 23b. Was decedent		23c. If yes, outcome			Ectopic pregnan	CV			23d. Date	of delivery	
Box	ne death certifica / the attending p ched for use as i	Completed by Physician/M	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 Pregnant 9 Unknown	at time of de		Other (specify)				Month	n Day	Year
P.O.	sician: The law requires that the decertificate has been signed by the rector, page 2 should be detached	y Ph			contributing to death	but not resu	Iting in the u	nderlying cause gi	iven in Par	tI.	23e. Did toba	cco use contribu	ute to the caus	e of death?
ds, l	quires t	led b				· -					1 🗌 Yes	2 □ No 3	☐ Probably	4 Unknown
COL	law rec nas be e 2 sho	nple								[24a. Was an autopsy	pric	re autopsy find or to completio ath?	fings available on of cause of
l Re	n: The ficate nr, pag		25. Was case refer	red to medical				06.5	None of Do		performe	No 1	Yes 2 N	lo
Vita	ysicia s certi directo	To Be	evaminer? -	Y €No	Hospital: 1 Inpa	tient 2 🗆 E	R/Outpatier		ner	eath <i>(Check onl</i> Nursing Home		ce 6 🗆 Other (Specify)	
of	ng Ph fter thi ineral	ate:]	27. Manner of Deat	h 5 Pending	28a. Date of inj (Month, Da	ury 2	28b. Time of injury	28c. Inju	ry at k?	28d.	-	injury occurred		
sion	death ctor: A y the fi	Certificate:	2 🖺 Accident 3 🔲 Suicide	Investigatio	oe 280 Place of In	iury - At hon	ne. farm. stre	M 1 =	Yes 2		Location (Stre	et and Number o	or Rural Route	Number.
Division of Vital Records,	tal or A	Sel	4 ☐ Homicide	determined		tc. (Specify)		, ,			City or Town,			,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director, page 2 should be detached for use as the burial-the completed filled in by the funeral director.	Medical	29a. Certifier (Check only one)	🛚 🖂 Medical Exam	vsician: To the best on hiner: On the basis of the Practioner: To the	examination	and/or invest	tigation, in my opini	ion, death d	occurred at the	time, date and	place, and due to	tne cause(s) a	nd manner stated.
	within a so a so a se a se a se a se a se a se	-	29b. Signature and		Abel		MD		205	2557		d. Date signed (f	9/20	11
				ress of person who Abebe	completed cause of	death (Item :	23a) (Type, F	rint)	7 dr	Dr 1	Rocki	ille h	ND 21	0820
	Sta		 Date filed (Mon 	th, Day, Year)	39. Regist	rar's Signatu	ire Ann	del.	-F-Y	- ·				
	Registr	ar	JI	JL 28 201	Cenu	U B.	19							

Herbert H. Joseph	State of Maryland / Department of Health	1 1 4 1 1 1 1
	1- For State Registrar Certificate of Death	and Mental Hygiene 2011 2569
Physician/	Decedent's Name (First, Middle,Last)	Date of Death 3. Time of Death
Medical Examine	nerbere m. oosepa	August 1, 2011 2032 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Tov Montgomery General Hospital Olney	wn, or Location of Death 4c. County of Death Montgomery
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	
Director	130-28-3818 1XM 2F 76 Yrs. Months	Days Hours Min. 12/28/1934 Foreign Country Germany
	Usual Residence of Decedent	
w any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
rland -fraho	MD Montgomery Silver Spring	1 X Yes 2 No
the Maryland or 28s-f sh tifted at ouce	10e. Street and Number 10f. Zip Co 3100 N Leisure World Blvd, Apt. #721 20906	
	3100 N 2023 021 W02-1 1	of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
leath with r items 23 sust be no		Cuban, Mexican, Puerto Rican, etc.) White, etc.
s after or rain, on other m		No specify: Specify: White
hours maturi	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Octubring most of working	ccupation (Give kind of work done ng life, DO NOT use retired) 16b, Kind of Business/Industry
36 in 72 han " dical J	Elementary/Secondary (0-12) College (1-4 or 5+)	Orthopedist
5-0036 Itel within 72 hour Hygiene. I other than "natu the Medical Exart Completed.	5+ Physician 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
21215 21215 July be file Mental Hy marked of ic event, the	Hans Joseph	Hilde Katzenstein
21 21 nould I Mer is man	19a. Informant's Name/Relationship (Type, Print)	(Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD and 2 sho m 27 is	Lauri Joseph - Wife 3100 N Leis 20a. Method of Disposition 20b. Place of Disposition (Name	sure World Blvd, Apt.#/21 Maryland 20906
Baltimore, pernit. Pages I ar Department of He Important: If ite	1 X Burial 2 Cremation 3 Removal from State crematory or other place)	
t. Pag t. Pag tment rant:	TA Donation 3 Other Specify.	Gardens 8/04/2011 Olney, MD
Bal Permi Depar Inpo	21. Signature Funeral Sq. ace License 22. Name and Ac Chapels	dress of Facility Danzansky-Goldberg Memorial , Inc. ckville Pike Rockville, MD 20852
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of c	dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Madiest	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerot	tic Cardiovascular Disease
Examiner	or condition resulting in death) Due to (or as a consequence of):	
<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ji e	Cause. Enter Underlying Cause (Disease or injury that initiated	
nsit Examiner	events resulting in death) Last Due to (or as a consequence of):	
executed ian and ial - transit	M UNPENDED AMENDED 23a, 27, per me, g918 8	-25-11 sm
50, te be e sysicia buria	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Box 68760, the death certificate be the attending physicing for use as the burn thy sician/Med	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy Month Day Year
Box (e death ce the attenced for use	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)
O. B nat the day the etached i	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I. 23e. Did tobacco use contribute to the cause of death?
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach Be Completed by P		1 Yes 2 No 3 Probably 4 Unknown
rds requir		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Records, The law require ficate has been significate has been significate has been significate has been significate has been significated.		performed? death?
Vital Recystian: The his certificate director, page		Place of Death (Check only one)
of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should the	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other:
n of \ ding Ph. After tl funeral	(Month, Day, Year)	c. Injury at Work? 28d. Describe how injury occurred
Division o spiral or Attending rours after death. meral Director: After filled in by the func Certification:	2 Accident Investigation	Yes 2 No
Jivis after A Directin b	3 Suicide 6 Could not be determined (Specify)	ffice building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
lospits 1 hours unera ly fille	29a. Certifier	me data and place, and due to the cause(s) and manner as stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Runeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burifiedical Certification: To Be Completed by Physician/Med	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or	
To th within To th compl	and manner stated 29b. Signature and title of certifier 29c. L	icense number 29d. Date signed (Month, Day, Year)
	GUIIIIAM C	D.C.M.E. August 2, 2011
	30. Name and address of person who completed cause of death (Item 23a)	OL AL PURI AND ALCOS
	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore	Street, Baltimore, MD 21223
State Registra	MITT 11 /2 /1111 F/	

			State of	Maryland / Depa	artment of H	lealth and M	lental Hy	giene	25693
_			Registrar	Cei	rtificate of	Deam		Reg. N201	
	Physicia /Medic		Decedent's Name (First, Middle, Last) HASSAN	JE	RU-AHMED		2. Date of De Month JULY	Day Year 2011	3. Time of Death 10:40 A ^M
	Examin		4a. Facility Name (If not institution, give street and numi	per)	4b. City, Town, o	r Location of Death		4c. County of Dea	th
		4	1604 Shady Glen Drive			rict Heig		Prince G	
	Funeral		5. Social Security Number 6. Sex 1 XM 2 F	'. Age (In yrs. last birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da		thplace (State or Foreign ountry)
E	Director		577-28-5069	87 Yrs.			March 9	, 1924	DC
1	A		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. inside City Limits
	fsho	ō	Maryland Prince George's		Dia	trict Hei	ahta		1 X Yes 2 No
	28a-	Director	10e. Street and Number		10f. Zip Code	tilet ner	gires	10g. Citizen of What C	ountry?
	Sa or	Ö	1604 Shady Glen Drive		207	47		United	States
-	ms 2;	Funeral	11 Marital Status 12. Was Deced	dent Ever in U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No		erican Indian,
9	or ite	Fu	Armed Ford 1 Never Married 2 Married 1 Yes, Give	:es? 2 □ No			rican, etc.)		
3	ral", c	by	3 ☐ Widowed 4 ☐ Divorced Year or Date	es: WW-II	1 ☐ Yes 2 🗷 No	Specify:		Specify: Af Am	erican
	natul dical	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most of worki d)	ing	16b. Kind of Business	/Industry
V :	med wintn /z nouts after death with the maryland plane. wher than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-			a) abilitati		Self-Emp	loved
	lygier it, th	ខ្ញ	12th		rug a ken			, Maiden Surname)	
2 3	ntal he ntal hed ot	Be	17. Father's Name (First, Middle, Last) Owens Whitney				,	Osborne	
Š	permit. Fages I and 2 should be filed within 7.2 hours after dearth with the Marylan apparament of Health and Mental Hygiene. Important: If item 2.7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ပ	19a. Informant's Name/Relationship (Type. Print)	19h Maili	nn Address (Street			er, City or Town, State,	Zin Code) 20747
ב ב	d 2 s th an t7 Is I		Monifa Ahmed - Daughter		-			ct Heights	
ָׁעַ	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Date	20c. Location - City o	
5	ages ent of t: If i		1 Burial 2 □ Cremation 3 □ Removal from S □ Donation 5 □ Other (Specify)	tate Kernetery, cre	matory or other place yland	July	29,	Chol+onho	ım, Maryland
	ortan ortan Injur	- 89	21. Signat /e \f Funeral Service Licensee	veteran 2	is Cemete: 2. Name and Addre			meral Home	, Inc.
ă	any per		I San Star	rout, 32/41	001 Benni	ng Road N	E Washi	ington, DC	20019
	o		23a. Part1. Enter the disease, or complications that ca shock or heart failure. List only one cause on ea	used the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between
⇒ F	hysician		immediate Cause (Final	IC OBSTRUCTI					Onset and Death
27	/Medical			or as a consequence of):	TE TOLKION	MICI DIOM			
١	xaminer		Sequentially list conditions, bb						
	sit a	Examiner	if any leading to immediate Due to (cause, Enter Underlying Cause (Disease or injury	or as a consequence of):					
	be executed ician and burial-transit	хаг	that initiated events c.	or as a consequence of):					
	be ey	alE	530 (0 (0	r as a somosquemos siy.					
0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		d						
4	nding se a	M/M		ome pf pregnancy				23d. Date of d	elivery
á	atte	iciai	in the past 12 months? 1 ☐ Live bit	ant at time of death 5	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y 		Month	Day Year
	by the achec	Physician/Medi	9 ☐ Unknown 9 ☐ Unknown	vn					
6	gned b	by P	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	ınderlying cause giv	ven in Part i.	23e. Did	tobacco use contribute	***
5	equire en sig ould b	ed t	ESSENTIAL HYPERTENSION				1 🗆	Yes 2 No 3 I	Probably 4 Unknown
כ ט	aw re is bed 2 sho	Completed	MULTI-INFARCT				24a. Was	an 24b. Were	autopsy findings available ocompletion of cause of
	ate ha	mo;	DEMENTIA				perf	ormed? death?	es 2 No
2	Attending Priystolan: The law r death. ector: After this certificate has t by the funeral director, page 2 s	Be C	25. Was case referred to medical examiner?			26. Place of Deat			
>	this ce	To E	1 XYes 2 No Hospital: 1 □ In	patient 2 ER/Outpatie	III JU DON		me 5 Res	idence 6 □Other (Sp	ecify)
	After t funera	on:	27. Manner of Death 28a. Date of 1 Manual 5 Pending (Month	f Injury 28b. Time o n, Day Year) Injury	Wo		28d. Describe	how injury occurred	
2	leath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place	1 A E]Yes 2□No	001 1	(0)	Down Control Number
7	or An	Certification:	determined 200. Flace	of injury - At home, farm, st g, etc. <i>(Specify)</i>	леет, тастогу, опісе			(Street and Number or i own, State)	nurai noute Nurriber,
	burs s purs s peral i		29a, Certifier 1 Certifying Physician: To the	pest of my knowledge, dea	th occurred at the ti	ime, date and place	and due to the	e cause(s) and manner	as stated.
	To the table to spin or Arterioring Privations. The taw requires that the death certificate with the house after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) Check only one Check one C	sis of examination and/or in					
	To th comp	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mo.	
	5		*Karer Elekther	1	MD#	33255		JULY 26, 2	011
	a		30. Name and address of person who completed cause						
	6)		KAREN ANN BLACKSTONE, M.	D., VAMC, 50	IRVING S	STREET NW,	WASHI	NGTON, DC 20	422/688

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [9] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 $\mathtt{July}^{\mathtt{Month}}$ Physician/ 20 7:45P M William George Kellum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Genesis Health Care-The Pines Easton If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 02-24-1938 1 M 2 🗆 F Maryland Director 214-36-5229 Usual Residence of Deceden 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location notified at filed within 72 hours after death with the Maryland Funeral Director 1 X Yes 2 No Md Talbot Easton 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number ms 23a or must be r 10 Village Street, Apt.81 USA 21601 ural", or items ! 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Divorced 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) William Kellum Restaurant 10 Cook ulth and Mental Hygie
27 is marked other
r traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) e 1 and 2 should be fill of Health and Mental ည Thompson Kellum Ella William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Village Street, Apt. 81, Easton, Md. 21601 Ross/Daughte permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr. Jacqueline 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-26-11 Easton, Maryland Richards Mem.Pk. gnature of Juneral Service Licensee 22. Name and Address of Facility
Bennie Smith Funeral Home 21601 426 Dover St., Easton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ OBSTRUCTIVE MRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death be detached g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death?
1 Yes 2 No this certificate Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pendina work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 only one the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R163758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Druman in Easton mo 21601 **علما**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25695 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 July 21, Pete Patrick Klapps 4:10 pm 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Emeritus Senior Living Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 □ F Months Days Hours May 01. 1924 Pennsulvania 205-03-7417 87 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9718 Braddock Road U.S.A. 20903 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify. WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mathematics Education 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Sardoni Louis Klapps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245 Christian Ridge Rd., South Paris, ME 04281 Stephen P. Klapps - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 07/27/2011 Silver Spring. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Licensee 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Unidentifying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) nown able zđ

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

Examiner

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permit. Page 1 a
Department of H
Important: If ite
any injury or ott

Funeral Director

Completed by

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed æ

29a. Certifie

only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-gransit Certificate: Medical

Division of Vital Records, P.O. Box 68760

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death	
Coronary Arte	1 ☐ Yes 2 😿 No 3 ☐ Probably 4 ☐ Unk	
Cerebral Vasc Hupertension	ular Accident	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 X Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	n (Nontri, Day, Year) Injury work? M 1 Yes 2 No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	280 Place of Injuny At home form street feeten, office	8f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

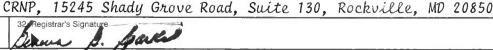
Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

6+1

31. Date filed (Month, Day, Year) JUL 28

John Hudson-Odoi,



address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

31. Date filed (Month, Day, Year)

			State Registrar	State of Maryland		artment c tificate c				iene leg. N <mark>2</mark> 0		25697
	Physicia Medic		1. Decedent's Name (First, Middle, Last) James Richard	Kyger, Sr.					2. Date of Deat Month	Day	Year	3. Time of Death /952 M
	Examir		4a. Facility Name (if not institution, give stre	et and number)	ker .	4b. City, Tow	or Location			4c. County	of Death	
ı	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da		/	8. Date of Birth		9. Birth Cour	place (State or Foreign htry)
	land f show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation						10d. Inside City Limits
	the Mary or 28a-1 e notifie	Funeral Director	MD Worces	ter Sr	now H	i 1 1 10f. Zip Coo	le			l 0g. Citizen of V	Vhat Cou	1 ☐ Yes 2 ☒ No
	h with t ns 23a nust be	neral	4038 Paw Paw	Creek Rd.			1863			USA		
900	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	2	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates.	If	/as Decedent of Yes, specify C	uban, Mexica	an, Puerto F	cify Yes or No- Rican, etc.)		k, White,	ean Indian, etc. ite
21215-0036	72 hou an "natu Medical	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give k	ent's Usual Oc ind of work do NOT use retii	ne during mo	st of workin	9	16b. Kind of Bu	siness In	dustry
1212	d withir fygiene ther the nt, the	Be Co	Elementary/Seconday (0-12) 9 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)		er/Ope	rato					Comapny
Maryland	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To E	William Kyger					her's Name nie I	(First, Middle, № am	laiden Surname)	
Mar	2 shoth ar th ar the ar trau		19a. Informant's Name/Relationship (<i>Type</i> , James R. Kyger, J	· '					Route Number,			· ·
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Rer	20b. Pla	ice of Dispos	sition (Name of atory or other				20c. Location -		
altim	permit. Page Department Important: I any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licen			tae Cr			/2011 rbage			
ñ	lmi any		1 Jus D	utale	10	08 Wil	liam	St.,	Berli	n, MD		
	Physician/		23a. P. 1. Enter the disease, or complicate shock, or heart failure. List only one callmmediate Cause (Final disease or condition	A A				s cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	rice of):		100000	سالاك				WEEK
	р #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):	379.	1-7.>					ZUESKS
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events c resulting in death) Last	Due to (or as a conseque	nce of):						\dashv	ZWEEKS
09/	physicia the bur	edical	d						<u> </u>		\rightarrow	
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnable to the funeral director.	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	If yes, outcome of pregnand 1 Live Birth 2 Fetal of 4 Pregnant at time of decenting	death 3 🖳	Ectopic pregn Other (specify				23d. Dat	e of deliventh	ery Day Year
л. О	that the ned by the detach	by Phy	9 Unknown Part II. Other significant conditions contrib		ting in the un	derlying cause	given in Par	t I.	23e. Did tob	acco use contri	bute to th	ne cause of death?
rds,	equires een sign nould be								1 □ Ye	s 2 🗆 No	3 🗌 Prol	pably 4 Unknown
Vital Records,	n: The law r ficate has b or, page 2 sl	Completed	25. Was case referred to medical						24a. Was an autops perform	y p	Vere autorior to co eath?	psy findings available mpletion of cause of
VITA	hysicia his certi	To Be	examiner? 1 Yes 2 No Hosp	oital:	R/Outpatient	10	Place of Dea Other: 4 🗆 N		only one) ne 5 🗆 Reside	nce 6 🗆 Othe	r (Specify)
on or	nding F ath. r: After t e funera	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	8b. Time of injury	. v	juryat ork? □ Yes 2 □		3d. Describe hov	w injury occurre	d	
DIVISION	ital or Atte urs after de ral Directo lled in by th		, E Homode determined	28e. Place of Injury - At hom building, etc. (Specify)				1	8f. Location (Str City or Town,	State)		
	ne Hosp in 24 hou ne Fune pleted fi	Medical	(Check / / Medical Examiner:	n: To the best of my knowled On the basis of examination a actioner: To the best of my k	เกต/or investic	at≀on, in mv or	inion, death c	occurred at t	he time date and	nlace and due	to the car	ise(s) and manner stated
	To the To the company of the company		29b. Signature and title of certiller			29c. Lice	nse number	/		9d. Date signed		
			30. Name and address of berson who comp	leted cause of death (Item 2	3a) (Type, Pri	int)		1	C At	Jay.	-8/	2011
	Stat	57 e	2001162	32. Registrar's Signatur) Ea	ot (a	moll s	Keel	Sall	shung	MD	21812
	Registra		31. Date filed (Month, Day, Year) JUL 2 8 2011	Cours &	. Spa	Mal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 25698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 23, Day 011 Year Physician/ 8:30 А м Alice Silas Knight Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Independence Court Hyattsville Prince George's Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🖾 F Hours Director 579-32-1510 84 Aug. Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6712 Weston Avenue 20743 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 72 hours after Completed by Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Secretary Government permit. Page 1 and 2 should be filed witi Department of Health and Mental Hygier Important: If item 27 is marked other I any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Earl C. Silas Laura Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarice V. Dowtin 5004 12th Street NE - Sister Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Lee's Crematory 4 ☐ Dopation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. To some 4001 Benning Road NE Washington, DC 23a, Pari 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest affock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demen Physician/ disease or condition resulting in death) Medical Tue to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be B examiner? 2 No ္ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the f 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Conflying Number action on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unly unvi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20102

Registrar
DHMH 17 Rev 7/2009

State

Suite 200

Largo, Md.

20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9200 Basil Court

32. Registrar's Signature

Ivan Zama, MD

31. Date filed (Month, Day, Year)

2 8 2011

			For	State of Ma	aryland / Depa				201	1 25700
			State Registrar		Cer	tificate of I	Death		Reg. No U	
	Physicia		Decedent's Name (First, Middle		0.4		LOPEZ	2. Date of Dea	Day 24 20	ar 17.29 M
	Medic	al	CAMILA 4a. Facility Name (if not institution	ANDREA	KAN	IREZ	r Location of Death	Jul	4c. County of E	
	Examin	er	SHADY GROVE F		SPITAL	ROCKVIL				OMERY
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9.	Birthplace (State or Foreign
	Director		none	1 □ M 2 💢 F	Yrs.	Months Days	Hours Min.	(Month, Day	24 2011	MARYLAND
	t ow	l. I	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	arylan a-f sh fied a	cto	Tour otato	gomery	Rockvi					1 🏿 Yes 2 □ No
	or 28%	Dir.	10e. Street and Number	30021		10f. Zip Code			10g. Citizen of Wha	t Country?
	23a	eral	1001 Rockvi	lle Pike	Apt.719	208	852		USA	
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It health and Mental Hyglene with a factor of them 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me ical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Vac Give	No.	Was Decedent of H If Yes, specify Cub	dispanic Origin? (Spean, Mexican, Puerto El Sal	ecify Yes or No- Rican, etc.) Vadora		American Indian, Vhite, etc. 1116
5-0	r2 hou "natu e ica	ple		nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done O NOT use retired	during most of work	ing	16b. Kind of Busin	ess Industry
12	ithin ithin ithe.	5	Elementary/Seconday (0-12)	College (1-4 or 5		none	,		none	e
Baltimore, Maryland 21215-0036	I be filed w fental Hygi rked othe tic event, i	l on l	17. Father's Name (First, Middle, Fredis Alex				Blanc	a Lope		
Mary	d 2 should be alth and Ment of 27 is marked or traumatic e		19a. Informant's Name/Relations Fredis Alexi		ther 19b. Maili	ng Address (Street	and Number or Run ville Pi	al Route Numbe .ke #71	r, City or Town, State	ille,Md
more,	Page 1 and of Heren II it is or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 6	3 ☐ Removal from State	20b. Place of Dispo cemetery, crer All So	osition (Name of matory or other pla ouls ce	m. 7/28	Date 3/2011	20c. Location - Cit	y or Town, State town , Md
Balti	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature urreral Service	4-					RAL SERV	ICE,P.A. ing,Md20910
			23a. Part 1. Enter the disease, o shock, or heart failure. List	complications that caused	the death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Pnysician/		Immediate Cause (Final disease or condition			ASTIC L	ungs			Onset and Death
March	Medical Examiner		resulting in death)		consequence of):					
		ē.	Sequentially list conditions,		KELETA	L 174	SPLASI	45		
	D 2	ΞĖ	if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury	Due ic for use	a consectant needs.					
	xecut al-rand	Exa	that initiated events resulting in death) Last	Due to (or as a	a consequence of):		 			
0	icate be executed g physician and as the burial-	ical		d						
876	ificate ig phy as the	Med	IF FEMALE:							
Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial tents.	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnar ☐ Other (spec <i>ify)</i> _	псу		23d. Date of Month	
P.O.	hat th ed by detac	by Ph	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the	underlying cause g	given in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
<u>S</u> ,	n sign	g p						1 🗆	Yes 2 X No 3	☐ Probably 4 ☐ Unknown
of Vital Records,	w requ	Completed						24a. Was	an 24b. We	re autopsy findings available or to completion of cause of
3ec	The la	ĕ						perfe	ormed? dea	ath? Yes 2 🕱 No
a	sician: The law i certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?				Place of Death (Ched	k only one)		
Ξ	hysic this ce al dire	욘	1 🗌 Yes 2 💢 No		ent 2 ER/Outpatie	nt 3 LI DOA			dence 6 Other	Specify)
סר	ling F I. After 1 funera	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pend		ry 28b. Time o injury	wo		28d. Describe	how injury occurred	
Division	or Attence death	Certificate:	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ		ury - At home, farm, st			28f. Location (City or To		or Rural Route Number,
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	xamination and/or inve-	stigation, in my opin	nion, death occurred	at the time, date	and place, and due to	the cause(s) and manner stated.
	To the within To the comple	Σ	29b. Signature and title of certific		2335 O. Try Kilowiouge,	29c. Licen	se number		29d. Date signed (I	Month, Day, Year)
U			30. Name and address of person	who completed cause of d	eath (Item 23a) (Type,				JULY 21	7 2016
	Sta	te	MISBAH. 31. Date filed (Month, Day, Year)	QURES H	eath (Item 23a) (Type, 9901 ME) ar's Signature	DICAL CO	ENTER DRI	VE R	OCKVILLE	MARYLAND
	Registr		JUL 282	U11 Sentera	p. ga					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:45 A 2. Date of Death Physician/ J MIN 22 Day 201 Year Eunice N. Leven Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Baltimore Randallstown 6. Sex If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) PA 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Months Hours July 14 1 M 2 X F Yrs 1918 **Director** 167-07-1923 93 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral or items 23a 14508 Homecrest Road #425 20906 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify White 1 Yes 2 XNo Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Nathan Tillie Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Leven/Son 30333 Hunters Drive #21 Farmington Hills, MI 48334 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Lebanon 7/24/2011 Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and AddressDæmænsky-Goldberg Memorial Chapels, 1170 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee mo1597 - Mcgreenhos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between End. Stage Dementia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 🗌 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes Accident
Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MSRajapanse M.D

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Rayapakse, M.D

31. Date filed (Month, Day, Year)

JUL 28 2011

2835 Smith

Registrar's Signature

00057465

703

Baltimore

21209

			For State Registrar	State of	Maryla	nd / Depa	artmen <i>rtificate</i>			and M			201		25702
	Physici		1. Decedent's Name (First, Middle Glory Alprin Le	. ,				0. 2	Juli		2. Date of De	eath			3. Time of Death 12:30 A _M
	Medi Exami		4a. Facility Name (if not institution	_	,				Location o	of Death	07724	4c.	County of De		
	Funeral		Brighton Garder 5. Social Security Number 133-14-1373		. Age (In yrs	last birthday)	Chev If Under Months		Idse If Under Hours	24 Hrs. Min.	8. Date of Bir	th	Montgo		ace (State or Foreign NY
	Director	1	Usual Residence of Decedent		85	Yrs.					087237	1925			" NY
1	Maryland 8a-f sh tified a	Funeral Director	MD Monts	romerv		ity, Town or Lo								10	d. Inside City Limits 1 X Yes 2 No
)_,	with the Mar 23a or 28a- ust be notifi	ralDi	10e. Street and Number			evy ona	10f. Zip					_	izen of What	Count	y?
	eath w	Fune	5555 Friendship 11. Marital Status	12. Was Deced	ent Ever in U		208 Was Deced	ent of His	spanic Orig	gin? (Spec	cify Yes or No-	USA	14. Race - Ar	nerica	n Indian.
036	hours after death with the Maryland natural", or items 23a or 28a-f show iical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Mar 3 🎇 Widowed 4 ☐ Divorced	If Van Cive			f Yes, speci			, Puerto F	Rican, etc.)		Black, Wh		c.
215-(i 72 hou an "nati Medica	Completed	(Specify only highe	nt's Education est grade completed)		16a. Deced	lent's Usua kind of worl O NOT use	k done di		of workir	ıg	16b. Ki	nd of Busines	s Indu	ustry
1212	d withir tygiene ther tha nt, the	Be Co	Elementary/Seconday (0-12)	College (1-4	or 5+)	Busin			ger			Labo	r Arbi	tra	ation
Maryland 21215-0036	1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Example.	고 B	17. Father's Name (First, Middle, L Morris Oscar Al	•					18. Mother		(First, Middle, nger	Maiden S	Surname)		
Man	2 should th and I th and I to me trauma		19a. Informant's Name/Relations								Route Numbe			Zip Co	ode)
ore,	ge 1 and 2 s nt of Health a : If item 27 i or other tra		Douglas Letter 20a. Method of Disposition		20b.	Place of Dispo cemetery, cren	sition (Nam	e of			nesda,		cation - City	or Tow	n, State
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		1 Burial 2 Cremation 4 Donation 5 Other (S	Specify)	Na	tional	Crema	itory	7		5/2011				, VA Trection
Ba	Dep.		21. Signature of Funeral 9 Vice I	> MOI	163		91 Rc	ckvi	lle	Pike	Rockvi	lle,	MD 20	852	2
	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o	only one cause on each	i line.			of dying	, such as o	ardiac or	respiratory are	rest,			Approximate nterval Between Doset and Death Years
	Medical Examiner		disease or condition resulting in death)	- C.	as a consec	ementia quence of):									rears
		iner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	b. Due to (or	as a curisec	quance of).								+	
	icate be executed I physician and Is the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or	as a consec	quence of):								\vdash	
09,	ate be e ohysicia the buri	edical	1	d											
Box 687	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn		Ectopic pr	reanancy	,			2	23d. Date of d	elivery	/
). Bo	the deatl	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unknov	nt at time of		Other (spe						Month	D	ay Year
3, P.O.	ires that the der signed by the a d be detached	l by P	Part II. Other significant condition		th but not re	sulting in the ur	nderlying ca	ause give	en in Part I.						cause of death?
ords	w require s been s s should	oletec	Acute renal fai	Lure							24a. Was		24b. Were a	utops	bly 4 Unknown y findings available
Rec	sician: The law certificate has birector, page 2 s										autop perfo 1 🗌 Yes	rmed?	prior to death? 1 🔲 Y		letion of cause of
Vital	lysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	nationt 2	ER/Outpatient	- 2 [] DO	Other	ce of Death				W	T.	Assisted
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investig	g 28a. Date of (Month,		28b. Time of injury		c. Injury a	4 □ Nur at ′es 2 □ 1	28	ad. Describe h	ow injury	occurred	еслу д.	Assisted TVIng
Jivisid	al or Atten s after deat I Director: d in by the	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of	Injury - At h etc. (Specif	ome, farm, stre	et, factory,	office		2	8f. Location (S City or Tow		Number or R	ural R	oute Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in b	Medical	(Check 2 Medical E	Physician: To the best xaminer: On the basis Nurse Practioner: Jo	of examinatio	n and/or investi	aation, in m	v opinion	 death occ 	curred at the	he time, date a	nd place :	and due to the	CALISE	e(s) and manner stated.
	withi comi		29b. Signature and title of certifier		w		29c.1	License r		,		29d. Date	signed (Mon 26/201	th, Da	
			30. Name and address of person w	who completed cause of 7758 Wiscon				ethe	sda.	MD 2	0814			<u>_</u>	
Į.	Stat Registra	e	31. Date filed (Month, Day, Year)			ture back			,						

		-	For State	State of	Maryland / Dep	artment of H rtificate of D			2011	25703
			Registrar 1. Decedent's Name (First, Middle	, Last)		tilicate of D	Calli	2. Date of Deat	th	3. Time of Death
	Physicia		Margaret		Lerch			July 21	, 2011 Yea	
	Medic Examin		4a. Facility Name (if not institution,	give street and numb		4b. City, Town, or	Location of Death		4c. County of D	eath
			Collingswood N	ursing Hom	e	Rockvil.	le		Montgom	ery
	Funeral		· · · · · · · · · · · · · · · · · · ·	6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 7,	Year) 9.	Birthplace (State or Foreign Country)
	Director		214-14-0852 Usual Residence of Decedent		91 Yrs.			Feb. 7,	1920	Maryland
	and Show	5	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla 18a-f	rect	Maryland Mont	gomery	Gaither	sburg				1 🎛 Yes 2 □ No
	a or 2	ا قِ	10e. Street and Number		•	10f. Zip Code			10g. Citizen of What	Country?
	nust	Funeral Director	347 West Side I	Orive, #201	L	20878			United	States
	death riter		11. Marital Status	12. Was Deced Armed Ford	es?	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	after al", ol xami	d by	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If You Give		1 🗌 Yes 2 🏻 No	Specify:		Specify:	White
21215-0036	nours natura ical E	Completed	15. Deceder	nt's Education	16a. Dece	dent's Usual Occupa			16b. Kind of Busine	
215	n 72 an "r Med	m	(Specify only highe Elementary/Seconday (0-12)	st grade completed) College (1-4	life [kind of work done do OO NOT use retired)	uring most of worl	king		,
7	withi giene ger th t, the	ပ္စ	12			cretary			Steel	Company
nd	filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Nan	ne (First, Middle, I		
S	uld be 1 Men narke natic		Henry	Lerch				Florenc		
Ma	2 sho th and 27 is r traur		19a. Informant's Name/Relationsh		1	ng Address (Street a			-	
ē,	Heal Heal tem 2		Elizabeth Roth/ 20a. Method of Disposition	Niece	20b. Place of Disp			Date Date	20c. Location - City	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the Z7 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		cemetery, cre	matory or other place	•	5/2011	Elkridge,	Maryland
alti	mit. F partm portal y injul		21 Surplure of Funeral Service L	-		2. Name and Addres				Maryrand
m	an In De		Muchae	and hill	Jakon 11	East Dee	er Park I	Or., Gai	thersburg	, MD. 20877
			23a. Part 1. Enter the disease, or shock, or heart failure. List of			er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
×.P	hysician/		Immediate Cause (Final disease or condition	_ a Corona	ary Artery D	isease				Onset and Death
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		ä	Cause (Disease or linjury		tension					
	n and	Exa	that initiated events resulting in death) Last		r as a consequence of):					
09	ath certificate be executed attending physician and for use as the burial cast	dical Examiner		d						
876	tificat ng ph as th		IF FEMALE:	1	7.5					
Box 687	th cer tendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live B		Ectopic pregnancy	y		23d. Date of Month	delivery Day Year
Bo	e deal the al	Completed by Physician/Me	1 ☐ Yes 2X No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unkno		Other (specify)			Worth	Day Teal
P.O.	that the desided by the sidetached f	/ Ph	Part II. Other significant condition	ons contributing to de	ath but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
S, F	ires that signed l	d b						1 □ Y	′es 2 🛛 No 3 🗆	Probably 4 Unknown
ord	require been si should	lete						24a. Was a		autopsy findings available
ec	sician: The law is certificate has k lirector, page 2 s	omp						autop: perfor 1 \sum Yes	med? deatl	to completion of cause of h? Yes 2 No
a F	ian: T rtifical rtor, p	Be C	25. Was case referred to medical			26. Pla	ace of Death (Chec		2 2 NO 1 1	res 2 🗆 No
ξ	Physici this ce al direc	일	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	npatient 2 ER/Outpatie	ent 3 DOA Othe	er: 4 🛭 Nursing H	lome 5 Aesid	ence 6 Other (S	pecify)
ol	ing Pl		27. Manner of Death 1	28a. Date o (Month	f injury 28b. Time o in, Day, Year) injury	work	?	28d. Describe ho	ow injury occurred	
0	ttend death tor: A the fi	Certificate:	2 Accident Investig	gation	Chairman Additional Service of		Yes 2 No	201.1 11 10		D. I.D. t. N
Division of Vital Records,	or Attend after death Director: / in by the f	Cer	4 Homicide determ		of Injury - At home, farm, st g, etc. <i>(Specify)</i>	геет, тастогу, опісе		City or Town		Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attent death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial completed.	Medical			st of my knowledge, death					
	ne Ho in 24 I ne Fu pletec	Med			s of examination and/or inve the best of my knowledge,					the cause(s) and manner stated. r as stated.
	To the vithin 2 comple	_ '	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Me	onth, Day, Year)
	T		Krh	- M.		D301	.32		July 22	, 2011
			30. Name and address of person				61 P-1		VID 20050	
	Sta	te	M. Rita Ghosh, 31. Date filed (Month, Day, Year)	п.р., 148] 2 . Re			or, Kock	cville, I	ш. 20830	
	Registr		31. Date filed (Month, Day, Year) JUL 28 2	1011 Cen	gistrar's Signature					

LONON, MARGIE

			Please Type or Prin						jible.			
	State of Maryland / Department of Health and Mental Hygiene 1 - State State Registrar Certificate of Death Reg. 2011 25704											
			Registrar 1. Decedent's Name (First, Middle, Last)	C	ertificate of L	Death	2. Date of Death	g. N U	1 1	3. Time of Death		
	Physicia		Margie Evangeline Lonon				July .	18 2	O'l	3240AM		
	Medic Examin		4a. Facility Name (if not institution, give street and number) Doctors Community Hospital	 l	4b. City, Town, or Lanham—S	Location of Death		4c. Count	y of Death nce G	eorges		
	Funeral Director			(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1929		place (State or Foreign htry) VA		
(1)	d t t	1 1	Usual Residence of Decedent	10c. City, Town or	Location					10d. Inside City Limits		
	arylan ia-f sh ified a	Director	MD Prince Georges	•	inton					1 X Yes 2 □ No		
	the M a or 28 be not	ä	10e. Street and Number		10f. Zip Code		11	Og. Citizen of		ntry?		
	th with ms 23; must J	Funeral	6802 Purple Lilac Ln.	The La	207:		-if. Vee on No	15	AZU	In the second		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates.	er in U.S.	 Was Decedent of Hi If Yes, specify Cuba Yes 2 X No 		Rican, etc.)	Bla	ce - Americ ack, White, y: Bl ā	etc.		
5-0	"natu "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occupive kind of work done	ation during most of work	ing	16b. Kind of E	3usiness In	ndustry		
77	iled within 7 Il Hygiene. other than vent, the M		Elementary/Seconday (0-12) College (1-4 or 5+	·)	. DO NOT use retired)	LPN		Health	care			
Baltimore, Maryland 21215-0036	be filed w lental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Odell Nichols			18. Mother's Nam	e (First, Middle, M Brown	aiden Surnan	те)			
lary	should be fill and Mental is marked (raumatic eve		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street a					Code)		
e,	and 2 s Health tem 27		Kamille Lonon / daughter 20a. Method of Disposition	1	2 Purple L			20c. Location		own, State		
mor	Page 1 ent of nt: If ii		1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify)	cemetery, c	rematory or other place	e)				·		
alti	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Sign but of Funeral (erv e Livensée)	Vece	22. Name and Addres	ss of Facility Str	rickland	Funera	al Ser	rvices		
8	20 5 8 0		23a. Part 1. Enter the disease, or complications that caused	the death Do not	6500 Alle				js, Mi	Approximate		
1	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		:lure	y, such as caldiac	or respiratory arres	s.,		Interval Between Onset and Death		
	Medical		disease or condition	consequence of):	, 141 6							
	Examiner	-e	Sequentially list conditions, b.						-			
	ted I Insit	Examiner	cause. Enter Underlying Cause (Disease or linjury	consequence of):					- 24			
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9	ate be physici the bu	dica	d		-							
Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Puneral Director: After this certificate has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of 1 □ Live Birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су			ate of delivionth	very Day Year		
P.0	that the ned by detact		Part II. Other significant conditions contributing to death bu	it not resulting in th	ne underlying cause giv	ven in Part I.				the cause of death?		
ds,	equires een sig ould b	ted }	Hypertension	- i			1 □ Y∈			obably 4 X Unknown		
900	law re has be ge 2 sh	Completed by	Congestive heart Fai	lure			24a. Was ar autops perforr	У	Were auto prior to co death?	opsy findings available ompletion of cause of		
Ä	an: The tifficate or, pag	Be Co	LUNG CANCEY 25. Was case referred to medical		26. PI	ace of Death (Chec	1 Yes 2		1 \(\text{Yes}	2 L No		
Vita	hysicie nis cer I direct	10 B		nt 2 🗆 ER/Outpa	atient 3 DOA Oth	or:	ome 5 Reside	nce 6 🗆 Ot	her (Speci	fy)		
Division of Vital Records, P.O.	ending P eath. or: After the	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 1 Natural 5 Pending (Month, Day,		ry work		28d. Describe ho	w injury occu	rred			
Divisi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.		, street, factory, office		28f. Location (Str City or Town		ber or Rura	al Route Number,		
	he Hospi iin 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check only one) 1	amination and/or in	vestigation, in my opinio	on, death occurred a	at the time, date an	d place, and c	lue to the c	ause(s) and manner stated.		
	To with		29b. Signature and title of certifier	pR	29c. Licens	e number	2	9d. Date sign	ed (Month)	Day, Year)		
			30. Name and address of person who completed cause of de	ath (Item 23a) (Typ	MDD De, Print) N+ Fox La	7066		-	10			
			Drinder Singh 14300 31. Date filed (Month, Day, Year) 32. Registrar	Galla	nt Fox La	we, Suit	re 124,	Bowie	, MI	20715		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar	r's Signature	•							

11-05833 Erin Lochary Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 25705

		1- For State Registrar	(Certificat	te of D	eath			Reg. No.		
Physicia	an/	1. Decedent's Name (First, Middle, I	_ast)					2. Date of De Month	Day Year	3. Time of De 0657 hrs	
ledical Exami	ner	Erin Lochary			40. 7	74. T ana asta		August 4	, 2011 4c. County of		•
		4a. Facility Name (if not institution, Howard County Genera	=			City, Town, or Lo Olumbia	ocation of Deal	n	Howard	Death	
Funeral				rs. last birtho		Under 1 Year	If Under 24Hr	s. 8. Date of B		9. Birthplace (State	or
Director		216-06-1770		30		onths Days	Hours Mi		7/1981	Foreign	MD
	ŀ	Usual Residence of Decedent	W 2 23F		115.						
any		10a. State 10b. County	10c.	City, Town or	Location					10d. Inside C	ity Limits
nd show	<u> </u>	MD Hov	ward	Elli	icott	City				1 Yes	2 🗓 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10	f. Zip Code	07.040		10g. Citizen of Wha	•	
th the Maryland 23a or 28a-f sho notified at once	盲	2937 Ebbwood	l Drive			•	21042		United	States	
n with	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S.		ecedent of Hispa		Specify Yes or N	o- 14. Race - White,	- American Indian, 81a	ack,
or ite	띪	1 Never Married 2 Marr	1 Yes 2 🗓	10				3 1 113411, 313.7		White	
s after	ā		lf Yes, Give Year or Dates:	1) I 4C= D		s 2 X No		work done	Specify: 16b. Kind of 8us		
5-0036 led within 72 hours Hygiene. tother than "natur	eted	 Decedent's Education (Specification) Elementary/Secondary (0-12) 	College (1-4 or 5+)	d) 16a. De		of working life. D			TOD. KING OF OUS	iness/industry	
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	John T. Lochar	Ÿ						3outchyar		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once	욘	19a. Informant's Name/Relationship		19b.	Mailing Ad	dress (Street a	and Number or	Rural Route Nu	mber, City or Town	, State, Zip Code)	ļ
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		John T. Locha: 20a. Method of Disposition				(Name of ceme		Date	t City,	City or Town, State	
		1 Burial 2 Cremation		cremator	y or other p	olace)	.			•	- 1
Page ment tant:	- 1	4 Donation 5 Other Spec	cify:	Arden		matory		3/08/11		ver, MD	
Baltimore, permit. Pages 1 at Department of He Important: If ite	- 1	21. Signature of Funeral Service Li			22. Name	and Address o	f Facility Ha	arry H.	Witzke's	Family Fity, MD 2	.H.lnt
Physician		23a. Part I. Enter the disease, or co									
Medical	- 1	failure. List only one cause or	each line.							Between O Dea	
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	a. Tramadol and Due to (or as a consequen		zoran	THUCKI	cation				\dashv
	.	Sequentially list conditions,	b								
	<u>ē</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequen	ce of):							- 1
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recuted and transit			d								
ial ia	edical	X UNPENDED	AMENDED 23a, 27	,28a-:	t,per	me, g91	8 8–25-	-ll sm			
	- ₹	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of		7 5 4 4 4	2	Ectopic pregr	20001	23d. Date of o Month	-	Year
Sox 687 leath certific e attending for use as t	cian	past 12 months?	4 Pregnant at time of	2 of death 5	Fetal d	(Specify)	_Lctopic pregi	апсу	World	Day	
Box 68760, ne death certificate by the attending physic red for use as the but	Physi	1 Yes 2 No 9 V Unkno	9 Unknown								
P.O. es that the gned by redetach	by P	Part II. Other significant condition	18 contributing to death but r	not resulting i	n the unde	rlying cause giv	en in Part I.			oute to the cause of d	
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of Vital Records, g. Physician: The law require ufter this certificate has been si neral director, page 2 should b	Completed									eath? ✔ Yes 2	No No
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Physic al dire	P	1 Yes 2 No		ER/Out		DON		ing Home 5		Other:	
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Division spital or Attendin hours after death. neral Director: /	ertificati	3 Suicide 6 X Could r	not be		dence		iding, etc.	or Town,		bhwod Dr	ibor, oity
Tospit 4 hour funers	ပ	29a. Certifier 1 Certifying Phy.	sician: To the best of my know				and place, ar				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Exami	Iner: On the basis of examinati and manner stated.	on and/or inv	estigation,	in my opinion, o	death occurred	at the time, dat	e and place, and du	ue to the cause(s)	
F is E is	Š	29b. Signature and title of certifier	and married stated.	Y	1	29c. License	number		29d. Date signe	d (Month, Day, Year)	
		66111	11X	4	5	O.C.M	.E.		August 5, 2	011	
-		30. Name and address of person w							1-		
8			ssistant Medical Exami	_	W. Balt	imore Street	t, Baltimore	e, MD 21223	} 		
Si Regis	ate	31. Date filed (Month, Day, Year)	2011 32. Begistrar's Sig	gnature	back	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ $\mathsf{Ju}^{\mathsf{Month}}$ Carolyn Yvonne Magruder 21 :43 Ρ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 1949 PA 1 M 2 X F **Director** 220-50-3827 June Usual Residence of Decedent or 28a-f show notified at 10a, State 10h. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Carroll Westminster 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 ms 23a or must be n 12 N. Bishop St., Apt. B 21157 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exar Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Burnell Calvin Utz Iva Edna Stouter 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 Thomas A. Magruder, Sr. 12 N. Bishop St., Apt. B Westminster, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/287201 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Owings Mills, MD Garrison Forest VA Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Myers-Durboraw Funeral Home moranno 91 Willis St. Westminster. 21157 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a con-Examiner Sequentially list conditions if any. leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and that initiated events resulting in death) Last Due to (or as a consequence of) burial ng physician a Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death n signed by the a q 🗍 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 perform Hospital or Attending Physician: The 2 No Yes 1 Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes After this c ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie WILL 0

Registrar DHMH 17 Rev 7/2009

State

STONER

DESTMUNSTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

STUBINIO

Please Type or Print in Black Indelible ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 24. Physician/ 10:05am Evelyn F. Mitchell Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Burtonsville Sanctuary at Holy Cross 9. Birthplace (State or Foreign Country) Michigan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/09/1921 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 379-20-7484 89 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a State 10c City Town or Location Director 1 🗌 Yes 2 🗓 No Silver Spring Montaomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20906 3703 Dulwick Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 1943—
If Yes, Give
Year or Dates. 1944 Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor's Office Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Sarah Gillis Arthur Ballard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. 2212 Washington Avenue, #202, Silver Spring, MD20914 Paul A. Mitchell - Son Date Ukn 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2011 | Arlington, Virginia Arlington Natl Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Due to (or as a consequence of): cancer disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 5 Other (specify) Pregnant at time of death 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate | 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \square Homicide within 24 hours a To the Funeral C Medical 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier D0069829 7-29 Jenseen RNagri 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, b. per INF, G935, 1/31/2013, WS
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Crystal Myers 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> Month July Physician/ 22 9:15 A Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's 3801 Southern Avenue # 103 Suitland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1967 Feb. 12, Months Days Hours Min. 1 □ M 2 🖾 F DC Director 579-06-5297 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Suitland Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20746 United States 3801 Southern Avenue # 103 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give ò Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 🗵 No Specify: Completed 3 Divorced 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Government Housekeeping 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Grace Myers David Myers 9a Informant's Name/Relationship (Type, Print) Foster Okyere — Husband Alicea Myers — Daughter 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6461 Pennsylvania Ave. Apt. 201 District Heights,
1477 Morris Road washington, DC 20020 2074 Daughter 20747 July 28 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Heritage 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road NE Washington, DC Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Die to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 2 X No Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causes
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kouatchou, mb D63748 Jocetyne July 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD 4041 Powder Mill Road Calverton, Maryland 20705 31. Date filed (Month, Day, Ye JUL 2 9 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2 Date of Death 3. Time of Death Month Day Medical Examiner MYLES MCLEAN 0512 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex If Under 1 Year If Under 24Hrs. 7. Age (In yrs, last birthday) ForeignWASHINGTON Country) Director 213-21-7626 Months Hours 1^X M 2 F 23 /19/1988 DC Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits DC WASHINGTON 28a-f show 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 1010 SOUTHERN AVE S.E. 20032 UNITED STATES Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No Yes 2 No specify: 3 Widowed Divorced If Yes, Give Year 27 is marked other than "natural", matic event, the Medical Examiner SpecifyBLACK \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) MYLES MCLEAN If item 27 is marked æ JACQUETTA VIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUETTA VIA/MOTHER 1010 SOUTHERN AVE S.E. WASHINGTON, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 XBurial 2 Cremation 3 Removal from State crematory or other place) GLENWOOD CEMETERY 7/27/11 WASHINGTON, D.C. Other Specify 21 Biggature of Funeral Service Dicenses 22. Name and Address of Facility CAPITOL MORTUARY 4.2.5 MARYIAND AVE NE WSHINGTON DE the mode of dying, such as cardiac or respiratory arres, shoot, **Physician** art I. Enter the disease, or complications that caused the ath. Do not enter failure. List only one cause on each line. Between Onset and /Medical a. Gunshot Wound M Back Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of 1 Yes 2 No 9 Unknown Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? è ۵. Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical Vital Be 26 Place of Death (Check only one) Hospital: 1 V Inpatient Other4 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes ₹ After 27. Manner of Death 28a. Date of Injury (Month, Day Year) Jul 20, 2011 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Certification: Subject shot Natura! 0420 hrs Director: 5 Pending 1 Yes 2 ✔ No after death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 6100 Block Dix Street, Washington , DC determined (Specify) Local Street 24 hours Fo the Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, State Registrar

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Baltimore, permit. Page 1 and Department of Heal	or othe		20a. Method of Disposition 1 □ Burial 2 🎛 Cremation 3	☐ Removal from State	cemet	ery, cren	sition (Name of natory or other place	9)		0c. Location	- City or To	own, State
Baltimore permit. Page 1 s Department of H	r injury	-	4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		CHESA		E CREMATI			STEVEN		HOME, P.A.
E De E	any ir once		23a. Part 1. Enter the disease, or con			2	00 SOUTH	<u>HARRISON</u>	STREET,	EASTO	EKAL N. MD	21601
Exam executed an and	dical niner	al Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a Due to (or a) Due		of): of):	re vilure					Approximate Interval Between Onset and Death
Records, P.O. Box 68760 The law requires that the death certificate be ate has been signed by the attending physici	detached for use as the	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal dea		Ectopic pregnancy Other (specify)	/			ate of deliv	rery Day Year
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Hospit 4 hour Funera	completed filled in by the funeral director, page	Medical	(Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of miner: On the basis of e urse Practioner: To the	xamination and	or invest	tigation, in my opinior	n, death occurred a	t the time, date and	place, and de	ue to the ca	use(s) and manner stated.
To the within 2	E ₀		29b. Signature and title of certifier	ml m)		29c. License	number	29	d. Date sign	Zol	*
			30. Name and address of person who	o completed cause of d	leath (Item 23a)	(Type, F	Print)	219 Sou	th Was	lingto		treet
8+1	Stat	e	31. Date filed (Month, 1) Yes	2011 32. Registra	ar's Signature	1	Print) Shan,	4.10		.00		
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			For State Registrar		Stat	e of M	larylan	•	artment o tificate o			ental Hy	giene Reg. No	701		25711
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed		ried 1 If Yes	Decedent led Forces? Yes 2 🔯 s, Give or Dates.	Ever in U.S No	1	Vas Decedent of f Yes, specify C			cify Yes or No- Rican, etc.)		14. Race - A Black, V Whelite	American Vhite, etc	
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For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ Ruth Ann Paugh 20:10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Min (Month, Day, Year) 4 25 1938 1 □ M 2 😿 F Hours **Director** 234-62-2570 04 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Kitzmiller Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PO Box 405 21538 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Paul Keplinger Josephine Sheets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 405, Kitzmiller, MD 21538 Charles Paugh-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

■ Burial 2

□ Cremation 3

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) I.O.O.F. Cemetery 7/26/2011 | Elk Garden, WV of Funeral Service Licen 22. Name and Address of Facility David A. Burdock Funeral Home PA N 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onser and D Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 5 Other (specify) Pregnant at time of death ☐ Pregnam
☐ Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy this certificate has page 2 performed? Yes 2 N Be (25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: ၉ 1 Yes SB/Outpatient 3 DOA 1 🗌 Inpatient 2 🖒 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After Natural 5 Pending Investigation Accident hin 24 hours after death the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Praylioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D23979 7,22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Goralski, M.D. 311 North Fourth St, Suite II, Oakland, MD 21550 31. Date filed (Month, Day, Year) **JUL 2 6 2011** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death

Physician	
/Medical	
Examiner	

Funeral Director 28a-f show

d other than "natural", or items 23a or 28a-f showevent, the Medical Examinar must be notified at within 72 hours after permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic even.

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Physician /Medical Examiner

executed and burial-tran physician s the burial Hospital or Attending Physician: The law requires that the death certificate be attending p for use as t signed by the a been si page 2 s has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Doris B. Rill July 4:35p. 20 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Long View Nursing Home Carroll Manchester If Under 1 Year | If Under 24 Hrs. | . Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year Days Hours 1 □ M 2 😡 F Months 215-20-9485 86 4/16/1925 MD Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Carroll Hampstead MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4626 Lower Beckleysville Rd. 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: white by 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Dickensheets Marie Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21074$ 19a. Informant's Name/Relationship (Type. Print) 4626 Lower Beckleysville Rd., Hampstead, MD Richard E. Rill, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Lutheran 7/27/2011 Uniontown, MD 21. Signature of uneral Sa 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimen's Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion; death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 07 - 2 (- 2 1 1 29b. Signature and title of certifier 29c. License number

WJL 3

ANSURIUA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

park

51705

DR. Westminster, MD21157.

11-05432 Jason L. Recker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 257 | 4

	ŕ	1- For State Certifica Registrar	ate of Death	Reg. No.	
Physici Medical Exam		Decedent's Name (First, Middle,Last)		Date of Death Month Day Year July 20, 2011	3. Time of Death 0837 hrs
		Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	4b. City, Town, or Location of Deal Salisbury	th 4c, County of Wicomice	
Funeral Director		5. Social Security Number 215-88-5140 6. Sex 7. Age (In yrs. last birth 12 M 2 F 36	rday) If Under 1 Year If Under 24Hi Months Days Hours Mi Yrs.	— ' 1	9. Birthplace (State or Foreign Cou Ma)ryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		10d. Inside City Limits
* .	č	Maryland Wicomico Salish	oury		1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
ith the 23s or		200 Woodcrest Ave. 11. Marital Status 12. Was Decedent Ever in U.S.	21804	USA	American Indian, Black,
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	 13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert 1 Yes 2 X No specify: 		
hours a natura Exami	ed by		ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use re		iness/Industry
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur c event, the Medical Exami	Completed	Elementary/Secondary (0-12)	Road Paver	Americ	an Paving Co.
215-1 e filed ral Hyg red ott	Be C	17. Father's Name (First, Middle, Last) John Francis Recker		ne (First, Middle, Maiden Surname) Ruth Disharoon	
212 hould b nd Meni is mari	T _O		Mailing Address (Street and Number or		, State, Zip Code)
MD and 2 shot alth and sm 27 is raumatic		Linda Cooper/mother 20a. Method of Disposition 20b. Place of	30931 Cooper Lane, Disposition (Name of cemetery,		MD 21853 City or Town, State
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 X Cremation 3 Removal from State Salisk	ry or other place) Dury Crematory 7/2	27/2011 Salisb	ury, MD
Bal permil Depar Impo		2) Standard of Funda Savic Licensee	22. Name and Address of Facility Holloway Funeral 501 Snow Hill Rd.	Home Professiona	l Association
Physician		23a. Part I. Enter the disease, or complications that Laused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest, shock, or hear	t Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Oxycodone Intoxica Due to (or as a consequence of):	tion		Death
6		Sequentially list conditions, b			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Ulsease or injury that initiated			
xecuted 1 and - transit	I Exar	events resulting in death) Last Due to (or as a consequence of): d.			
ਤ ਜ਼ਿਲ	/Medical		per me,g919 9-23-	ll sm	
	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn	23d. Date of d Month	elivery Day Year
BO)	hysi	1 Yes 2 No 9 Unknown 9 Unknown	***************************************		
ires that the signed by the detached	ed by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contrib	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	Completed			autopsy pri perform <u>ed</u> ? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
tal Re	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check		
of Vital Physician: er this certif	욘	1 Yes 2 No No Inpatient 2 Y ER/Out	patient 3 DOA Other Nursi me of Injury 28c. Injury at Work?	ng Home 5 Residence 6 28d. Describe how injury occurred	Other:
ion of ttending Pl leath. stor: After / the funera	ation:	1 Natural (Month, Day, Year)	8:00 am 1 Yes 2 x No	Unknown	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	4 Homicide determined (Specify) Resid	m, street, factory, office building, etc.	28f. Location (Street and Number or Town, State) 200 Woo Salisbury, Md.	or Rural Route Number, City odcrest Ave.
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.			
H & H 3	ž	29b. Signature and title of certifier	29c, License number		(Month, Day, Year)
		Yangle Yvithell, ms	O.C.M.E.	July 21, 201	1
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimore Street, Balt	imore, MD 21223	
St		31. Date filed (Month, Day, Year) 2611 32. (egistrar's Signature)	bere		

			For State of Maryland	-	artmen <i>tificate</i>			and M		giene Reg. No.2 (257	15
П	Physicia	in/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ith	Year	3. Time of Dea	ath
	Medic Examin	cal	FREDERICK ORWIG SNYDER 4a. Facility Name (if not institution, give street and number)		4b City	Town or	Location o	of Death	07-21		ity of Death	935 A	М
تمد	Examin	lei	WILLIAM HILL MANOR			STON		Death			ral BOT		
	Funeral Director		5. Social Security Number 6. Sex 1×10^{-1} 7. Age (In yrs. las $294-03-6734$	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birt 08-13-1	917	g, Birthp Coun	place (State or Fo	reign
	ow tt	L	Usual Residence of Decedent	Town or Loc	ation						1.	0d. Inside City Li	imaite
	larylar 3a-f sk ified a	Director	100,010,	STON	Jadon						[1 1 Yes 2	
	the M or 28	١	10e. Street and Number	BION	10f. Zip	Code				10g. Citizen o	f What Cour		
	h with nust b	Funeral	501 DUTCHMANS LANE APT109		21	601				USA	A		
	r deat or iten niner r	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married	13. V	Vas Deced Yes, spec	ent of His fy Cuban	spanic Orig n, Mexican,	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		ace - Americ ack, White,		
93	rs afte Iral", (Exan	ed b	1 ☐ Never Married 2 💢 Married 1 💢 Yes 2 ☐ No If Yes, Give Year or Dates.	1	☐ Yes	2 X No	Specify:			Speci	fy: Whit	e	
2-0	"natu	plet	15. Decedent's Education (Specify only highest grade completed)		and of wor	k done du		of workin	g	16b. Kind of	Business Inc	lustry	
21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	SALES	NO <i>T u</i> se MANA	,				TURBIN	IES/CO	MPRESSOF	RS
pu	er the	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,			THE RESIDEN	
Maryland	uld be fil Mental marked natic ev	<u>ا</u>	FREDERICK B. SNYDER				JANE	P. 0	RWIG				
ā Z	2 sho	1 7	19a. Informant's Name/Relationship (Type, Print) Mary E. Snyder (Daughter)		-				Route Number er Harl				
<u>6</u>	of Health of Health fitem 27 rother tra		20a. Method of Disposition 20b. Pla	ce of Dispos	sition (Nam	e of	i		ate nat	20c. Location			
<u>=</u>	<u> </u>		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Ches 4 ☐ Donation 5 ☐ Other (Specify)	metery, crem Sapeak Cei	atory or of Cre nter	mat 3	lon 7	7-22-	2011	Stevens	ville	. MD	
Baltımore,	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee) Fe		Addreed S • H	elfeility	ibein	& New	nam Fur	eral	Home P.A	A.
	E = 10 01	Н	23a. Part 1. Enter the disease, or complications that caused the death.						East 01		1601	Approximate	-
	hysician/	ļ.,	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	-	/	/	1 /		respiratory an	551,		Interval Between Onset and Deat	n th
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequent of the control of the co	nce of):	nei	70	1/4	2			-	days	
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	d d ansit	dical Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Dro	0/6:	rin	1/2 0	len	Rent	16.	1 2	Neek	
	ate be executed ohysician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequer	nce of):	1								
3	cate be physic s the b	edic	d									_	
200	certifi anding use as	In/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal of	y	Fatania -					23d. D	Date of delive	ry	
POX	requires that the death certifics been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown 9 ☐ Unknown		Other (spe					N	1onth	Day Year	
7. Ö.	nat tne ed by t detach	y Ph	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying c	ause give	en in Part I.		23e. Did to	bacco use cor	ntribute to th	e cause of death	1?
S,	uld be	ed by							1 🗆 1	es 2 No	3 🗌 Prob	ably 4 🗆 Unkr	nown
Vital Records,	aw req as bee 2 shor	Completed							24a. Was a			sy findings availa	
L L	rnysician: The law r this certificate has k iral director, page 2 s	Con							perfor	med2	death?	_	
<u>.</u>	sician certifi irector	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I I I I I I I I I			Other	ce of Death						
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VISION OF	leath. or: Aff	Certificate:	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	n ijury	М	work?	′es 2 🗀 !	No					
NIVIS	after d Direct	Cert	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory,	office		2	8f. Location (S City or Town		ber or Rural	Route Number,	
	to the troughtal or Attending Priystcant. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled Check 2 Medical Examiner: On the basis of examination at	nd/or investi	gation, in m	y opinion	, death occ	curred at t	he time, date ar	d place, and d	ue to the cau	se(s) and manner	stated.
	vithin (only one) 3 Certifying Nurse Practioner: To the best of my keeps. Signature and title of certifier	nowledge, de	eath occurr	ed at the License r	time, date a	and place	and due to the	cause(s) and r	manner as sta	ted.	
			· HAT IN	>		02.	575	U			2/11		
-			30. Name and address of person who completed cause of death (Item 23						1.601		1.11		
8	イソト Stat	e	Robert Sanchez, MD 508 Idlewil 31. Date filed (Month, Day, Year) 32/Registrar's Signature			Eas	ston I	MD 2	1001				
	Registra	-	31. Date filed (Month, Day, Year) JUL 25 2011 32 Registrar's Signature 8.	AM	All I								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28 ate of Manyland 18,087 18,091 Health and Mental Hygiene 0 | | State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 08 201^{Ye} Stanley Keith Stever 8:40 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1157 Bethlehem Road Garrett 0akland If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1**X** M 2 □ F Months Hours Min. 11 02 1947 MD Director 218-48-8848 63 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No MD 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1157 Bethlehem Road 21550 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) building carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Myrtle Marie Gauer Keith Willard Steyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Bethlehem Road, Oakland, Sarah Steyer-wife MD 21550 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 8/6/2011 Cumberland, MD 22. Name and Address of Facility David A. Burdock Funeral Home PA 21, Signature of Funeral Service Licenses 21 N. 2nd St, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician Cervica disease or condition Medical resulting in death) 109 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Physician: To Be 25. Was case referred to medica of Vital 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury oc Subject fell table. Hospital or Attending off inversion Natural 5 Pending Division 1 Yes 2 No 09/13/2009 Unknown Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1157 Bethlehem Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined **Home** Oakland, MD Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause of the cause (Check 2 Medical Examiner. On the 23 Certifying Nurse Practioner: 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

AUG - 4

32 Registrar's Signature

Thomas G. Johnson, M.D., 311 North Street, Suite II, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} <u>011</u> Physician/ J_{uly}^{Month} 23 0345 Α. Saxton Angela Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday. **Funeral** . 19<u>26</u> Months Hours Min. Country) Director 048-16-8197 84 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21157 452 Logan Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 N Divorced White Completed if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Educator/Guidance Counselor Public Schools Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Sarah Cartelli Samuel Attardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5104 Bonnie Brae Ct. Ellicott City, MD Valerie Sharpe/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Evergreen Mem. Park 7/26/2011 Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee 22. Name and Address of FaciPritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or carditions) Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): for use as the burial-transi signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pr 23d. Date of delivery anant 3 Ectopic pregnancy in the past 12 month onths? Month Pregnant at time of death 5 Other (specify) Unknown culting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 🗌 Yes 2 🖺 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes 2 1 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 🗹 No Hospital: Other: 1 ☐ Yes ၉ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suiciae4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) etermined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nu se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature WIL 17 o completed cause of death (Item 23a) (Type, Print) Westminster, Mb. 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death July 25, Day 2011 Physician/ 0220 Suddath William Burnard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Golden Living Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 | F Months Days (Month, Day, Year) MD Director 80 218-24-3102 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 X Yes 2 No Westminster MD Carroll 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 24 Hillside Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Korea Completed 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Butcher Safeway 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Eldridge Suddath Sofie Alice Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shit of Health a Diane Suppa/daughter 433 S. Franklin St., Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Carroll Cremation Inc 07/26/2011 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil Pritts Funeral Home & Chapel, 21. Signature of Funeral Service Licensee 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of) physician sthe burtal Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) the 9 | Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pr within 24 hours after death.

To the Funeral Director, After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) eted cause of deat (Item 23a) (Type, Print) ne and address of person who con

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 2011 24 Oneida Shillingburg 0550 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Golden Living Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** July 13, 1 □ M 2 🔀 Director 85 219-22-2859 Usual Residence of Decedent show aţ 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director or 28a-f st notified a 1 Yes 2 XNo MD Carroll Westminster ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21157 **USA** 525 Mark Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Examiner Armed Forces þ ō 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 XWidowed 4 Divorced White Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Pre-School Elementary/Seconday (0-12) College (1-4 or 5+) Director and Teacher Methodist Church and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roy Eccard Violet Duff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Shillingburg/son 3803 Walt Mill Ct. Ellicott City, MD 21042 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/28/2011 Randallstown, MD Signature of Funeral Service Licensee 22. Name and Address of FaciPritts Funeral Home & Chapel, PA K 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown Month Day Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After it completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

WIL 10

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

(Check only one) 29b. Signature

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genine

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Consagra

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ralph Fenton Stone JULY 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Lanham Doctors Community Hospital Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. Yrs. 1934 Washington, Director 76 577-46-6614 July Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 X Yes 2 No MD Prince George's Colmar Manor 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20722 USA 3604 39th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 \sum No Army Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marken within 12 hours after any injury or with þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1954-56 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Western Electric 12 Tradesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fenton T. Stone Alice V. Ashburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14205 Old Marlboro Pike, Upper Marlboro, MD 20772 Tracy D. Stone / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 8/1/2011 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. FailURE Immediate Cause (Ffhat Onset and Death EGRT Physician/ ONGES disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the pleted filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

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29b. Signature and title of fertifie

only one)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

TIMORE AVENUE, SuitE509

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	Physicia Medic	al	GERALD RODNEY						(D- vi)	7 ^{Mo} 2 ^t 1-		Year	1730 м	
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	Funeral Director		5. Social Security Number 215–38–1208	6. Sex 7. A	nge (In yrs. la	ast birthday) Yrs.	If Under 1 Yea Months Days		der 24 Hrs. s Min.	8. Date of Bi			thplace (State or Foreign untry)	
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altimore, mit. Page 1 and	nent of I int: If its iny or of		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S			ESAPEAI	KE ^{ry} CREM2 NTER	TION	1	Date -2011		ation - City or		
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Division of Vital Records, all or Attending Physician: The law requires	within 44 nouts arter death. To the Funeral Director, After this certific completed filled in by the funeral director, to	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of I	njury - At ho	ome, farm, stre	M 1 leet, factory, office	Yes 2	□ No			Number or Ru	ral Route Number,	
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he Hos	the Fun the Fun tipleted	Medical	(Check 2 Medical E only one) 3 Certifying	xaminer: On the basis of Nurse Practioner: To the	examination	n and/or invest	igation, in my opi	nion, death	occurred a	t the time, date	and place, a	and due to the	cause(s) and manner stated.	
10	To t		29b. Signature and title of certifier	0.11)	02	29c. Licer	nse numbe	-7 / /	5	29d. Date	signed (Mont	h, Day, Year)	
			30. Name and address of person	who completed cause of	death (Item	23a) (Type, P	rint)	109	>[]		17		- 1	
10+	-VA Stat	te	Dennis De 31. Date filed (Month, Day, Year)	e Shrelc 32. Regis	rar's Signat	2 (9 ture	500-	th	سامره	shing	tay	>+2	Easton MU	
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DHMH 17 Rev 7/2009

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ı	Physicia		1. Decedent's Name (First, Middle, Ralph Li	Last) nn Tingler	·			2. Date of Dea		Year	3. Time of Death 4:20 a M	
	Medic Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Funeral			6. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year	Finksburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth				Carroll 9. Birthplace (State or Foreign	
	Director		236-20-6985 Usual Residence of Decedent	1 X M 2 □ F	89 Yrs	Months Days	Hours Min.	sep 9,	" 1921	West	Virginia	
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced		ver in U.S. 1	3. Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2 🕱 No	an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race Black, Specify:	- America , White, e whi	etc.	
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Baltimore,	t. Page 1 ar tment of H rtant: If ite		20a. Method of Disposition 1	3 ☐ Removal from State ecify)	cemetery, c	sposition (Name of rematory or other place ourg Cemet	ery //2	Date 4/2011	20c. Location - C	ourg	, MD	
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	Physician/ Medical Examiner but the print transit street the print transit street transit stree	Examiner	23a. T. 1. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linter Unidentified Cause (Disease or linjury that initiated events resulting in death) Last	a. Due to (or as a b.	consequence of):	Entia Gera					Approximate Interval Between Onset and Death	
O. Box 68760	the death certif by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ Ho g ☐ Unknown	23c. If yes, outcome of the line of the li	2 ☐ Fetal death 3 time of death 5	B ☐ Ectopic pregnand			23d. Date Mont	th	Day Year	
ds, P.O.	requires that been signed I should be det		Part II. Other significant condition	s contributing to death bu	it not resulting in th	e underlying cause gi	ven in Part I.		obacco use contrib Yes 2 No 3		e cause of death?	
of Vital Records,	The law re cate has be page 2 sh	Completed by							pri rmed? pri	ior to con ath?	osy findings available inpletion of cause of	
/ital	ysician: The is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 100	Hospital:		- Oth	lace of Death (Chec				Arcichad	
on of \	vttending Phy death. ctor: After this y the funeral d	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day,	nt 2 ER/Outpar y 28b. Time Year) injury	of 28c. Injur	y at		dence 6 Gother ow injury occurred		Living place	
Division	To the Hospital or Attenc within 24 hours after deatt To the Funeral Director; completed filled in by the i	I Certificate:	3 Suicide 6 Could not 4 Homicide determin	ot be		street, factory, office					Route Number,	
	To the Hospi within 24 hou To the Funer completed fill	Medical	(Check 2 Medical Exonly one) 3 Certifying N	Physician: To the best of n aminer: On the basis of ex- lurse Practioner: To the b	amination and/or inv	estigation, in my opini	on, death occurred a	at the time, date a	nd place, and due t	o the cau	se(s) and manner stated.	
	MIT		29b. Signature and title of certifier	ense	WD	29c. Licens			29d. Date signed (
	4NA		30. Name and address of person w	no completed cause of de	ath (Item 23a) (Type	Print Walco	1m du	ve, h	restmin	Hy	MD	
	Stat Registra	е	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	backel				, -	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25724 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 201^{Yea} Benjamin Edward Uzzelle, Jr. 7:40 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery . Social Security Number 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday) 80 Yrs, If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Coldsboro, N.C. 577-40-1078 12/11/11/1930 Director Usual Residence of Decedent 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 49th Pl., N.E. 20019 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 751 - 53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 and Mental Hygiene. 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced Specify. Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Custodian Metro Transit System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Benjamin Edward Uzzelle, Sr. Mary Lucille Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Loretta S. Uzzelle/Wife 49th Pl., N.E., Washington, D.C. 20a. Method of Disposition
1 ঐBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Quantico Nat'l. Cem. 08/01/11 Triangle, Virginia 21. Signature of Funeral Service Licensee Henry S. Washington & Sons Co., Inc. Tau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year signed by the at d be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ျှ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide within 24 hours after deatl To the Funeral Director. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

State Registrar

DHMH 17 Rev 7/2009

1000

29b. Signature and title of certifier

eev 31. Date filed (Month, Day, Year)

ecin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

grooll

7600

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 25725 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month July 20. Physician/ 3:15 ам Einar Vinten-Johansen 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery 10500 Rockville Pike. #1602 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Min Country) Denmark Hours 220-44-3931 96 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State 10b County Director notified Rockville 1 **X** Yes 2 □ No Montgomery Maryland 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? must be 23a by Funeral U.S.A. 20852 10500 Rockville Pike, #1602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 5 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Caucasian "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Anesthesiologist Medical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic even ဂ Ingrid Vinten Hans Johansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 7425 Venice Street, Falls Church, Virginia 22043 Dorte Vinten-Johansen/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1
Burial 2
Cremation 3
Removal from State Brentwood, Maryland Lincoln Crematory 07/28/2011 4 Donation 5 Other (Specify) MOI 102 22. Name and Address of Facility Simple Tribute Funeral & Crematio f Funeral Service Licensee 21. Signature 1040 Rockville Pike. Rockville. MD 20852 Center. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ a Alzheimer's Dementia unknown disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? for Month Day Year detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 X N 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 은 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at X Natural 5 Pending Investigation work? 2 No the f Accident within 24 hours after deat To the Funeral Director: completed filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

28

Rahul Patel, 600 Executive Blvd., Suite 625, N. Bethesda, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25726 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month D2 011 7:20 P M 18-4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Dorchester Cambridge Mallard Bay Nursing & Rehab. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Country Md. 214-16-4596 Hours Min. 8-3-1921 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Md. Tilghman Talbot 1 ☐ Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 4807 Black Walnut Pt. Road 21671 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1 X Yes 2 □ No Black, W 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Army 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) D. Eva Ensor Edward Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 236 Tilghman, Md. 21671 Mary Corinne Willey/ Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 7-22-2011 Md. Veterans Cem. Hurlock 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Harrey & Ostrowski Funeral Home P.A. P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oeset and Death Immediate Cause (Final ementia Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of):

Physician/ Medical **Examiner**

attending physician and for use as the burial-transit

been signed by the should be detached

124 hours after death.

• Funeral Director: After this certificate has letted filled in by the funeral director, page 2 to

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Completed by Physician/Medical

Be

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Certificate:

Medical

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified to once.

Baltimore, Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

230	If	yes, outcome of pregnancy
200.		
	1	Live Birth 2 Fetal de
	4	D. D

3 Ectopic pregnancy eath 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day

9 Unknown

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No

IF FEMALE:

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

autopsy

4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical

26. Place of Death (Check only one)

24b.	Were autopsy findings available prior to completion of cause of
	death?
	1 Yes 2 No

Year

examiner? 2 No 1 Tes 27. Manner of Death

Natural

3 ☐ Suicide 4 ☐ Homicide

Accident

5 Pending Investigation 6 Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year)

Hospital:

28b. Time of injury Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number,

29a. Certifier

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and addyess of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar

Johnson 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

Registrar's Signature

100

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Please Type or Print in Black Indelible 181/1 Freure All Copies Are Legible. Amend 23a per med cert State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2:00P N **Physician** 2011 24 Franklin B. Woy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Alleg.
9. Birthplace (State or Foreign Country) Westernport

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) AV . 203 Marsh 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** 1□ M 2□ F Months 9 - 15 - 27MD 83 Director 213-24-6941 Usual Residence of Deceden 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examlner must be notified at 1∏Yes 2∏No Director MD Alleg. Westernport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21562 203 USA Marsh AV. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) Electrician Westvaco Corp 12 Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Rachael R. Gross <u>Earl C. Woy</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition Warter AV . Westernport 20c/ Location : City or Town, State Mary R. Woy 20a. Method of Disposition Wife Baltimore, Pages ' 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Peter's Cem 7-27-11 Westernport, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fredlock F.H. 21. Signature of Funeral Service Licenses William 31 Jones St. Piedmont, WV. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TVE YUMPS Physician CHRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Five years Atherosclerotic Renovascular Disease School and the second state of the second sec Due to (or as a consequence or) Examine Due to (or as a consequence of): Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No Vital Records, P.O. signed by the detached 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed?

1 Yes 2 No certificate has Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ Division or filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After t Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and this of capifier 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1068 NATIONAL HIGHWAY LAVALE, MAKTIND AMES R. MUEN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 27 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Willet Physician/ Month 7:15 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Hospital Center Carroll arroll 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign ial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Feb. 17 Days Min. Year) 1930 Maryland Director 218-26-5736 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2612 Tyrone Road 21158 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. ģ 1 Never Married 2 Married ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) teller banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Earl Rill any injury or other traumatic Jennie Gertrude Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a If item 27 is Robert D. Willet - husband 2612 Tyrone Rd. Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a Department of H Important: If iter 20c. Location - City or Town, State Method of Disposition

1 Method of Disposition

2 Cremation 3 Removal from State Pleasant Valley Cemi 7/27/201 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Myers-Durboraw Funeral Home
136 F. Baltimore St. Taneyt Signature of Funeral Service Licensee ustin R. bokaw <u>мр 21787</u> E. Baltimore_St_ 🛰a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death strick, or heart failure. List only one cause on each line Immediate Cause (Final Huper tension Physician/ UMUNAU disease or condition resulting in death) GPAV Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Dien to for an a nonnequence off Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) bunialnding physician Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TibrillAlia~ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Pinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31666 7(23111 WIT 6 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue WESIMINSTER manyand THOMA CALVIN 11 Storen 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. 20 25729 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 201 WISE 0135 AM MYRTLF LEE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 1 M 2 K Oct. 3, Hours Min Year 915 402-09-4401 Kentucky 95 Yrs. Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits must be notified at Director Maryland | Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral items 23a 303 Adclare Road 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 2 No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Montgomery County (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Assistant Librarian other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other. ပ Earl Campbell Bertie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter W. Wise 6845 Windwillow Drive, New Port Richey, FL 34655 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 26, cemetery, crematory or other tropolitan Crematory 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Alexandria, Virginia 2011 DeVol Funeral Home, 21. Signature of Funer | Forvice Licensee 22. Name and Address of Facility M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or beart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition day Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal deat
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 🔲 Yes 2 💢 No Day Year Month 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by , Depression, Hyperkalemia; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Trust Infection, Hepath's unspeahed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred s after deau. ral Director: Aftr 1 X Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 10

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Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Shadygrave Adventit Hispatel, 9701 Medical Center Drive

M.D

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Stephen

,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $J_{\mathbf{u}}^{\text{Month}}$ 25, 2011 8:30 Рм William J. Walsh Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Sykesville Copper Ridge Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🛂 M 2 🗆 F Months DC 579-56-5720 66 **Director** 03/07/1945 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 1 🔀 Yes 2 🗌 No Bethesda MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Apt. 702 20814 4821 Montgomery Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Real Estate Real Estate Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ William J. Walsh Jr. Frances Greeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4821 Montgomery Lane #702 Bethesda, MD 20814 19a. Informant's Name/Relationship (Type, Print) Stephanie Walsh / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cometery, crematory or other place)
Gate of Heaven Cemet. 7/29/2011 1 X Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I

completed filled in by the funeral director, pag Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident
3 Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 🖃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Day, Year)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) **JUL 28 2011**

29d, Date signed (Month,

Reisterstown, MD 21136

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death July 21 Physician/ 2011 Helen Walsh A^M 7:15 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5101 Westpath Way Bethesda Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Dakota 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Min. 09/23/192 1 M 2 X F Director 579-18-4697 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is answed other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Rethesda 1X Yes 2 ☐ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20816 5101 Westpath Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Armed Forces 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
NUTSE Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Rundvold Malene Nesheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11617 Hitching Post Lane, N.Bethesda, MD 20852 Thomas Walsh/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Gate of Heaven Cem 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-25-2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. the 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ischemic Cardiomyopathy Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate sauss. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Tes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 🔀 No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 TResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the Completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending iniurv Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D37142 July 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

JUL 28 2011

Geoffrey Coleman MD 1355 Piccard Drive Suite 100 Rockville, MD 20850

#32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Physician/ + hen WALKER 2235 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Month Olvey MONTGOMEL Social Security Number **Funeral** 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days Min. 1 XM 2 | F Months Hours **Director** 187-05-4387 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outber than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Silver Spring | 10f. Zip Code MO Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20905 USA <u>4735 Good Hope Rd</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify. 3 🗌 Widowed 4 🗆 Divorced Year or Dates Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14735 Good Hope Road, Silver Spring, MD 20905 Mable Walker/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lisbon, MD 7/23/2011 Cemetery Signat e Funeral Service Licen 22. Name and Address of Facility Snowden Funeral Home 246 N.Washington Street, Rockville, MD 20850 eo 23a. Part 1. Enter the disease, or complications that caused the death, to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ DCAROIA disease or condition Medical resulting in death) ue to (or as a consequence of **Examiner** HEROSCIETOT 24 ROIGUASCULAR TEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No page 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in a stated of the cause of the (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature D06702L

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2 Date of Death Physician/ Month Jackie Vernon Wood Medical 4a. Fagity Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBAIA NICONICO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 10/12/ **Funeral** Days 1 🙀 M 2 🗆 Director 39-36-4016 81 MO Usual Residence of Decedent items 23a or 28a-f show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 No Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21811 USA 8060 Purnell Crossing Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Texaco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Meek Wood Frankie McCleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21811 / wife Purnell Crossing Rd., Berlin, MDHilda Wood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Trinity Garden of 7/29/2011 ☐ Donation 5 ☐ Other (Specify) Newark, MD Memory Address of Facility Burbage Funeral Home 08 William St., Berlin, 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Neumonia disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, bading to him ediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed ite Due to (or as a consequence of). resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tyes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. E Funeral Director: After (Month, Day, Year) work?
1 \[\text{Yes} 2 \[\text{No} \] 1 Natural 5 Pending injury Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29d. Date signed (Month, Dav. Year) 29c. License number +126 vame and address of person who completed cause of death (Item 23a) (Type, Print) BA 8+1

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State Registrar 00

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give stree number 4b. City, Town, or Location of Death County of Death **Examiner** Prince Regional George's Hospita -aurel aure Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Country) Thana Month Day Months Hours Min 1 🗆 M 2 🐷 Director ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City Town or Location Director 1 Yes 2 No Taome 10e. Street and Numbe 10g. Citizen of What Country? Funeral ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. or i 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other 20a. Method of Disposition 20b. Place of Disposition (Name of Dațe 20c Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic W102 MAN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and normaliered filled in by the funeral director, page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ☐ Live Birth ∠ ☐ Fetal God ☐ Pregnant at time of death ☐ Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D56433 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd. spital, Emergency Dept Laurel, MD 20707 Sendi, MD Christopher Laurel Regional Hospital . Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death ^{Day} 2011 Physician/ P Wall Cecil Hasty 22 12;32 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Hebron 27042 Tourmaline Drive Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 01/29/1924 248-22-9738 87 South Carolina **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? mit. Page 1 and 2 should be filed within 72 hours after death with the astriment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or "hiury or other traumatic event, the Medical Examiner must be I "hiury or other traumatic event, the Medical Examiner must be I. 21830 USA Funeral 27042 Tourmaline Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ...2 Coast Maryland 21215-0036 If Yes, Give Coast Year or Dates. Guard 1 Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Phone Company Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eva Anna Hasty Charlie W. Wall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Spring Ave., Salisbury, MD 21804 Patricia Parks/Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date Page 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 7/27/2011 Salisbury, MD Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21904 21. Signature of Funeral Servi Li, ensee 16eth 61 45F brins 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHECINOMA BLADDER disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last and -trans Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 Unknown signed by the sold be detached to P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, MULTIPLE MYELOMA 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed plnous een 24b. Were autopsy findings available prior to completion of cause of death? TROSTATE CHURCINOMA 24a. Was an Hospital or Attending Physician: The law is certificat has director, p.ge 2 s autopsy 24 hours after death. • Funeral Director. After this certificat. Nated filled in by the funeral director, pc∈ ☐ Yes 2 ☐ No 2XN Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum_{\text{Residence}}\) dence 6 \(\sum \) Other (Specify) 1 Tyes 2 ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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Year)

29b. Signature and title of certifier

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31. Date filed (Month, Day,

only one

30. Name an

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State

Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

32.

IRAUITZ

Registrar's Signatur

29c. License number

D36576

1665 WOODBROOKE DE SALISBURY

29d. Date signed (Month, Day, Year)

MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Dorothy Wagner 12:30 Marian 24 July Medical 4a. Fallity Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death KICOMICO 5AUB641 Year If Under 6. Sex If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min New Jersey 157-16-9388 84 Director Yrs Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 ¥ Yes 2 □ No Fruitland Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 101 Liberty Way 21826 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martha Manewitz Earl Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Liberty Way, Fruitland, MD 21826 Clarence Wagner/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Salisbury Crematory 1 Burial 2 X Cremation 3 Removal from State 7/26/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²HOTIOWAY Fundral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21826 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ 2045 NUTTRE STORM disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 40245 DORTK VALLE BERLEFMEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine EM35 Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed WATE STENOSIS attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death Month Day the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed certificate 2 N 1 Yes 2 No 25. Was case referred, to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: Mangler of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred After 5 \square Pending 1 Natural thin 24 hours after death. the Funeral Director: Af mpleted filled in by the fu ☐ Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

210 State

within 2 To the F

29a. Certifier

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only one) 29b. Signature and title o

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

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Date filed (Month, Day, Year)

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Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Salisbury

29d. Date signed (Month. Day, Year)

7011

29c. License number

D535

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 20 Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Tate Chesapeake Hospice House Linthicum If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours January 24, 1947 England 64 **Director** 171-54-5242 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Gambrills Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21054 989 Summer Hill Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceud. Armed Forces? 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry uth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Information College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Database Administrator Technology Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Sylvia Audrey Dustan Ryan George Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 989 Summer Hill Drive, Gambrills, Maryland 21054 William B. Aumiller, Jr./Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State West Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State August 4 Donation 5 Other (Specify) 2011 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licensee Will Elsone M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy death?
1 Yes 2 No Yes 2 certificate **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 WNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at ICE Certificate: 28d. Describe how injury occurred After 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 201 npleted cause of death (Item 2)

State Registrar Name and address of person who NEVIEVE

1

Date filed (Month, Day, Year)

23a) (Type, Print)

DG-HT-061-17A

DEFENSEHWY, ANNAPOLIS, MD-21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 201 Medical Facility Name (if not institution, give street and number) **Examiner** or Location of Death MUYSIN anur 4rman If Under 24 Hrs. If Under 8. Date of Birth 7. Age (n yrs. last birthday Year 9. Birthplace (State or Foreign **Funeral** -3662 Months Days Min. Month Day, 89 **Director** Maryland Usual Residence of Decedent 28a-f show ms 23a or 28a-f shorms must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2095 ROCKROSE AVENUE 21211 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc ö þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify WHITE "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LIOUOR STORE 10 CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ge 1 and 2 should be fil nt of Health and Mental :: If item 27 is marked VINCENT ALFONSI THERESA BARRANCO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY SULLIVAN-GUARDIAN 10 N CALVERT STREET BALTIMORE, MD 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/12/2011 GARDENS OF FAITH BALTIMORE, MARYLAND Signature of Buneral Service License 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR ROAD BALTIMORE, MD 21206 23a Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) rogressi Medical Due to (or as a co Examiner some Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury mme burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month the 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? Dementia 24a, Was an has page 2 certificate 2 No Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital 2 \ No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: It the bast of my knowledge, death content at the fine, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D31464 MD 8/8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAW ST Shite 308 BALTIMORE MD 21201 SITUAIR A HASIMI MD 31. Date filed (Month, Day, Year, . Registrar's Sig State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:45 PM M August 2, 2011 Melvin John Alexanderwicz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 37 Cornhill Street Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 8, 19 Birthplace (State or Foreign Country) unk 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 X M 2 □ F Director 76 143-26-5842 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show id other than "natural", or items 23a or 28a-f show event, the Wedical Evan, the routh of the 1 ☐ Yes 2 No Annapolis Director Anne Arundel 10f. Zip Code 21401 10g. Citizen of What Country? USA 10e. Street and Number 37 Cornhill St. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?unk 1 ☐ Yes 2 ☐ No Black White etc. filed within 72 hours after of Hygiene. 1 □ Never Married 2 □ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give 3 ☐ Widowed 4 🖾 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, It. Modis once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) healthcare psychiatrist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kate Alexanderwicz John Alexanderwicz ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6126 Hampton Dr North; St. Petersburg, FL 33710 Linda Alexanderwicz - daighter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rs of Funeral Survice 22. Name and Address of Facility State Anatomy Board 21. Signat Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 23a, Part 1. Immediate Cause (Final disease or condition resulting in death) terioscleroti **Physician** / /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the The law requires that the death certificate as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 ☐ Yes should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a..
autopsy
performed?
Yes 2 No has page 2 s certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

2

eout

ause of death (Item 23a) (Type, Print)

Registrar's Signature

29d. Date signed Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 201 4c. County of Death 4a. Facility Name (If not institution, give street and number) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) 1 □ M 2 € F 0 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 ■Yes 2 No MARYLAND MORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 04 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STEWARTSTOWN FAIR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) ChOTNACKI 21. Signature of Fuperal Service Licensee 1005 DUNDAIK AVE, BALT, MORE MAYLANG 23a. 11. If ter the disease, or complication, in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one call e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ocard Due to (or a consequence of) Sequentially list conditions, if any least sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify)

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If Item 27 is marked othe
any Injury or other traumatic event,
once.

Physician

/Medical

Examiner

10a, State

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Evaminer must be notified at

Funeral Director

Completed by

Be

2

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

31. Date filed (Month, Pay, Year AUG 12

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed the burial attending ph for use as th the detached signed by to certificate within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral.

Division of Vital Records, P.O. Box 68760,

9 ∐ Unknown						
Part II. Other significant conditions		ulting in the underlyin	g cause given in Part I.		tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknow
O steo	arthritis			per	s an 24 opsy formed?	b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referred medical			one)			
examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Inpatient 2 I] ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5 Re	sidence 6 🗆 🤇	Other (Specify)
27. Man f Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	e how injury occ	curred
3 Suicide 6 Could not to determined		tory, office	281. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying P	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plac tion, in my opinion, death occ	ce, and due to the curred at the tim	ne cause(s) and e, date and plac	manner as stated. ce, and due to the cause(s)
29b. Signature and title of certifier			29c. License number		29d. Date sig	ned (Month, Day, Year)

Ball MD 21224

BOV

State Registrar

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 餐

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		For State Registrar			State c	of IVIa	aryian			ent of tale			Mental Hy	_	20		257	41
Physicia	- /	Decedent's Name	e (First, Middle	e, Last)									2. Date of D Month	eath		Voor	3. Time of I	
Medic	al	Joyce 4a. Facility Name (if	D.		Brow				1			45	Augus			2011	11:0	0 PM
Examin	ier	110 Spru			eet ana nun	nper)			4b. (Dity, Town, o I	r Location Pasad			4	lc. County Ann		undel	
Funeral		5. Social Security N	umber	6. Sex	M 2 🖫 F	7. Age		st birthda	Man	nder 1 Year ths Days	If Unde	er 24 Hrs. Min.	8. Date of B	irth ay, Year)	9. Birth Cour	place (State or	Foreign
Director		216-44-5 Usual Residence of		, _				65 Yrs			<u> </u>		March (Month, E	29	1946		MD	
yland -f shov ed at	ctor	10a. State 10b. County 10c. City, Town						, Town or	Location								10d. Inside City	,
or 28a	Dire	Maryland Anne Arundel 10e. Street and Number 10f. Zip Code							Pasadena				Citizen of \	Mhat Cou	1 \(\text{Yes} \)	2 🔼 No		
with the s 23a c	Funeral Director	110 Spri	110 Spruce Avenue								21	122		rog. (USA			
death r item	/ Fun	11. Marital Status			. Was Dece Armed Fo	rces?		5. 1	3. Was D	ecedent of H specify Cuba	lispanic O an, Mexica	rigin? (Span, Puerto	ecify Yes or No Rican, etc.))~		e - Americk, White,	can Indian, etc.	
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12 sho lith and 27 is r r traur		19a. Informant's Na E li zabet			<i>Print)</i> (daugh	nter	.)		_				al Route Numb sadena ,	-			Code)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Saa of 28a-f show mortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 🔀 Burial 2		2 🗆 Do	manual from	Ctata		lace of Dis		(Name of or other place	ce)	Aug	Date 15	20c.	Location -	- City or To	own, State	
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Medical Examiner		resulting in death)		r	Due to	(or as a	consequ	ence of):									·	
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sician: The law requires that the death certificate be certificate has been signed by the attending physici rector, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent	months?	230	i. If yes, out 1 Live 4 Preg	Birth 2	2 ☐ Fetal	I death		pic pregnaner (specify)	су					te of deliv		′ ear
the de	hysi	1 Yes 2 9 Unknown			9 Unkr		time or d		o 🗆 Otine	(upcony) _								
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Physic this ce al dire	욘		No h	Hos	spital: 1 28a. Date			ER/Outpa			4 L r		ome 5 Res				0	
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r Atte ter de irector n by th	ertif	3 Suicide 4 Homicide	6 Could determ				y - At hoi (Specify)		street, fa	ctory, office			28f. Location City or To			er or Rura	Route Number	er,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier 1	Certifying	ı Physicia	an: To the b	est of n	ny knowle	edae dea	th occure	d at the time	date and	d place at	nd due to the c		Ĺ	or ac ctate	ad .	
he Hos in 24 h he Fun ipleted	Medical	Check 2	: 🔛 Medical E	xaminer	: On the bas	sis of ex	amination	and/or inv	vestigatior	ı, in my opini	on, death o	occurred a	at the time, date ce, and due to t	and place	ce, and du	e to the ca	use(s) and mar	ner stated
With Voit	3.5	29b. Signature and	title of certifier	10	1/20	6	5			29c. Licens			3		ate signe	d (Month,	Day, Year)	
		30. Name and addre	ess of person	who com	pleted caus	se of de	ath (Item	23a) (Tvn	e. Print\	10	00/	777		Cu	51	1) 3	1011	
U		5505	ER	ite	hie	H	Sho	ug y	((Bro	ob (YIY	40, 2	42	25			
Stat Registra		31. Date filed (Mont)		6	32. R	egistrar	's Signati	ure										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mugust 4 ay 20 Year 7:24 James Blake . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number 6. Sex 1 X M 2 \square F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7 Age (In vrs. last hirthday) 8. Date of Birth **Funeral** Days Hours Min oc (Hont) 3 ay, 1926 Mary land 84 Yrs **Director** 212-22-1349 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral USA "natural", or items 23a 21239 1803 Lydonlea Way within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 2 Yes 2 No 1942-Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 1945 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Martin Marietta Department of Health and Mental Hygien Important: If item 27 is marked out any injury or other. laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Blake Agnes Johnson 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 1803 Lydonlea Way; Baltimore, Maryland 21239 Margie Blake - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Watte 22. Name and Address of Facility State Anatomy Board Dixector 655 W. Baltimore St; Baltimore, MD 21201 rt 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or he allure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for sels consequence of, If any, leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

Funeral Director: Af bleted filled in by the fu 2 🗌 No 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completed within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only or 29b. Signatu and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item (\$3a) (Type, Print)) State 32. Registrar's Si

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and Nertificate of Death		ene 2 0	11	25743	
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	g. 140.		3. Time of Death	
	Physicia Medic		Jack Myron Benson		August	10°, 2	0199	7:50 P M	
	Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
أنميد			9338 Harvey Road	Silver Spring		Monto			
	Funeral Director		5. Social Security Number 6. Sex 1X M 2 \square F 77 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth NOV 7	(°8'33	9. Birthp Count Onic	lace (State or Foreign ry)	
-			300-28-6102 77 Yrs. Usual Residence of Decedent		1100 //	755	OIII		
	f shoved	tor	10a. State 10b. County 10c. City, Town or L	ocation			10	0d. Inside City Limits	
	28a-	irec	Maryland Montgomery	Silver Spring				1 🗆 Yes 2 🔀 No	
	ith the	Funeral Director	10e. Street and Number	10f. Zip Code	10	10g. Citizen of What Country? United States			
	ath w	nue	9338 Harvey Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	20910 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		e - America		
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933	urs aff ural", al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.1954—1955	1 Tyes 2 X No Specify:		Specify.	Whi	te	
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<u>Iar</u>	d be t Menta arked	오	Julius M. Benson	Florence	e Ione	Evans			
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nor	Page 1 nent of ant: If it ury or o		1 Burial 2 X Cremation 3 Removal from State cemetery, cre	ematory or other place)			-	aryland	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatte event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) Final Jour	ney Crematory 8/16					
Ä	Imp Per any		Gwerly & Hechiatte MO1251 E	61ng Homes Crematic everly L. Heckrott	ce, P.A.	Clarks	ville	, MD 21029	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,		Approximate Interval Between	
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XO	atten atten i for u	iciar	in the past 12 months? 1 Ves 2 \(\text{No.} \) 1 Ves 2 \(\text{No.} \) 4 Pregnant at time of death 5	Control of the contro				Day Year	
О	requires that the de been signed by the should be detached	hys	9 ☐ Unknown						
P.	s that gned	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.				e cause of death?	
rds,	en si ould b	ted			1 L. Ye			pably 4 Unknown	
000	has by	Completed			24a. Was an autopsy perform	/	Were autor prior to cor death?	osy findings available inpletion of cause of	
Ä	Physician; The lav r this certificate hav aral director, page 2		25. Was case referred to medical		1 Yes 2		1 Yes	2 🗆 No	
/ita	siciar certif	o Be	examiner? 1 Yes 2 X No	26. Place of Death (Chec	lome 5 🔀 Resider	C	er (Coosifi		
of \	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe hov				
ono	anding sath. or: Aftu he fun	ficat	2 Accident Investigation	work? 1 ☐ Yes 2 ☐ No					
VİSİ	al or Attending F s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,		er or Rural	Route Number,	
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deat	n occured at the time, date and place is	and due to the caus	e(s) and mann	er as state	d.	
	e Hos n 24 h e Fun eleted	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred	at the time, date and	place, and du	e to the car	use(s) and manner stated.	
	To the within to the complete		29b. Signature and title of certifier	29c. License number	29	d. Date signe	d (Month, i	Day, Year)	
	100			D29675	I	August	11,	2011	
	34/8/		30. Name and address of person who completed cause of death (Item 23a) (Type		MD 20047				
	Sta	e	Ralph Boccia 6420 Rockledge Dr. Ste	e. 4100 Bethesda,	MD 2081/				
	Registra		31. Date filed (Month, Day, Year) AUG 12 2011 Leven 8. Sauce						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 25744 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2011 5:50 P M Louise M. Behrend Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, Director 1916 Washington DC 133-26-3919 94 Usual Residence of Decedent 28a-f shov 10b. County at 10c. City. Town or Location the Maryland 10d. Inside City Limits Director notified 1 Yes 2 X No <u>Maryland</u> Montgomery Chevy Chase 10e. Street and Number items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 4450 S. Park Avenue #819 20815 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces Black, White, etc. ö þ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Musician Music event, Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any Injury or other there is an any Injury or other the in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin B. Behrend Frances Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Paull O'Connell/POA 5008 44th St. NW Washington, DC 20016 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/10/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses Sing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or result tory arrest, shock, or heart failure. List only one cause on each line. Approximate mt Interval Between Immediate Cause (Final Onset and Death Physician/ Left Hip Fracture disease or condition Medical ME resulting in death) Examiner Due to (or as a consequence of): Debility Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of 10 physician and s the burial-transit Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Year Pregnant at time of death Day signed by the a Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performe certificate ! 2 🗌 No JYes 2 XNo 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 X Yes 2 No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSpice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After Natural 5 Pending 2X Accident 07/24/2011 lunk 1 Yes 2X No Investigation Subject fell Funeral Director: Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 4450 S. lat home 24 hours Chevy Chase Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 371 Poly August 3, 30. Name and address of person who completed Gause of death (Item 23a) (Type, Print) Coleman 6001 Muncaster Mill Rd. Rockville, MD 20855

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State Registrar AUG 1 2 2011

p. parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hy	giene	05715
			1 - State Registrar Ce 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Dea	Reg. No. U	25/45
	Physicia Medic	al	JOHN R. BREED		Honth	7° 2011	3. The of Death
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Funeral		109 6th Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Laurel If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h 9. Bi	rthplace (State or Foreign
	Director		577-70-2333 1 M 2 □ F 61 Yrs.	Months Days Hours Min.	Jan. 18,	1950	ountry) VA
	nd how at	۲	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Li	ocation			10d. Inside City Limits
	faryla 3a-f s iffied	ecto	MD Prince George Laurel				1xxYes 2 ☐ No
	the N or 28	Ι	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	h with	Funeral Director	109 6th Street	20707		USA	
	r deat ir iten	y Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
980	s afte ral", c Exarr	ed by	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
2-0	2 hour "natu	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	kina	16b. Kind of Business	Industry
121	thin 72 ane. than he Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	00 NOT use retired) tsman	9	Aerospace	
d 2	led wi Hygie other ent, tl	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle,	Maiden Surname)	
/an	d be fil fental rrked tic ev	2	James Dalton Breeden, Sr.		olumbia		
Maryland 21215-0036	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Numbe	r, City or Town, State, Z	ip Code)
ک ش	and 2 Health em 27 ther tr		Wanda Daye Breeden/Wife 109 20a. Method of Disposition 20b. Place of Disp	6th Street, Laure		*-	T 01.1
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Barylandrath: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🔣 Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)	Date ug 11, 2011	20c. Location - City o	
äţį	mit. P. sartme sortan injur.			ndel Crematory 2. Name and Address of Facility Don			
m	permi Depar Impor any ir			313 Talbott Ave.,			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory an	rest,	Approximate Interval Between
	Physician Medical		resulting in death)	ncer			Onset and Death
	Examiner		Due to (or as a consequence of):				
		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	cuted nd transit	Examiner	Cause (Disease or iinjury that initiated events c.				
	ate be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
760	cate to physic street	ledic	d				
89	aath certifica attending p	an/N	IF FEMALE: 23b. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of d	elivery
Box 687	death he attu	Physician/Me		Other (specify)		Month	Day Year
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
S, F	uires th	ed by			1 🗆	Yes 2□No 🎾	Probably 4 🗌 Unknown
örc	w requision been shou	Completed			24a, Was		utopsy findings available completion of cause of
Bec	Physician: The law this certificate has al director, page 2 !	Som	11V			ormed? death?	
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)		
Ž	Phys r this or	<u>ان</u>	27. Manner of Death 28a. Date of injury 28b. Time of	ent 3 🗆 DCA 4 🗀 Nursing H		dence 6 Other (Spenow injury occurred	cify)
uc	nding ath. r: Afte ie fune	icat	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident ☐ Investigation	wórk? M 1 ☐ Yes 2 ☐ No		· · · · · · · · · · · · · · · · · · ·	
Division of Vital Records,	r Atte ter de irecto ir by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tou	Street and Number or R	ural Route Number,
Ö	pital cours at course at cours at course at co		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	angurad at the time date and place of	and due to the ca	une(a) and manner as s	tatad
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, deam only one)	stigation, in my opinion, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated.
	To th within To th comp	-	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
			· ceal join to	10158/	2	Huy8	Zell
ク、	/		30. Name and address of person who completed cause of death (Item 23a) (Type ROR 693V A	Vinha Blui	1 Cle	9 Burain	21061
	Stat		31. Date filed (Month, Day, Year) 32. Suistrai's Signature				
	Registra	ar	AUG 1 2 2011 / Dema 1. 1	arke			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (2 Year **Physician** EMERSON BARRET AHZINHO 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 ALTIMORE COUNTY 4pm BALTIMORFIMD MERCY AL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F NIA Director BAUMUREIMD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No BALTIMORE COUNT Completed by Funeral Director MD MCUAS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3903 2113 MSYY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ⚠ No BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be BARRET NIKKO JRTIS SHILDIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 is any injury or other tra 3903 RUMD, RANDAU STWW, MD 21133 MIKKO JACKION. MUTHER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Balto., Ms 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Itome Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner TERM PREMATURE RUPTURE MEMSHAVES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit death certificate be executed and Due to (or as a consequence of): burial physician the burial Box 68760. Physiclan/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ANo 2 **X**No 1 🗌 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aff completely filled in by the fur 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

AUG 12 2011 August 12. Registrars Signatu

30. Name and address of person who

DHMH 17 Rev 1/2001

ST Paul

Place

Balhmore, Mi

11-05620 Ric

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	State of Mary	land / Departme				11 2574				
Physician/ edical Examiner	Decedent's Name (First, Middle,Last) Richard D.	Barbeau		Mor	e of Death	3. Time of Death 1935 hrs				
	4a. Facility Name (if not institution, give street and Atlantic General Hospital		4b. City, Town, or Berlin		4c. County of Wicomico					
Director	5. Social Security Number 6. Sex 1 M 2 I	7. Age (In yrs. last birtho	day) If Under 1 Yea Months Days Yrs.		ate of Birth (MM/DD/YYYY) 3/25/58	9. Birthplace (State or Foreign Country)				
A BOX	Usual Residence of Decedent 10a. State									
thours after death with "matural", or items 23. Examiner must be no ted by Funeral	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes or Pates: 15 Decedent's Education (Specify only highest generatory/Secondary (0-12) College	Forces? 2 No 'ear rade completed) 16a. De	13. Was Decedent of His If Yes, specify Cuban 1 Yes 2 X No ecedent's Usual Occupat ring most of working life.	ion (Give kind of work dor DO NOT use retired)	Specify: 16b. Kind of Busin	American Indian, Black, atc. White ness/Industry				
21215-0036 uld be filed within 72 hours a Mental Hygiene marked afther than "matura c event, the Medical Examin To Be Completed by	12 17. Father's Name (First, Middle, Last) Robert Barbeau	0	Sales Repre		Middle, Maiden Surname) Watson	ofing 				
∑ 232 ∑	19a. Informant's Name/Relationship (Type, Print) Nasque Barbeau /Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 218 Sandy Way, Coatesville PA 19320 20a. Method of Disposition (Name of cemetery, 1 Plurial 3 Committee 3 XXP proposition (Street and Number or Rural Route Number, City or Town, State, 218 Sandy Way, Coatesville PA 19320 20c. Location - City or Town State, 220c. Location - City or Town State, 23c. Locat									
MOCA Pages 1 sent of 1 unt: If	1 Burial 2 Cremation 3 Remova 4 Donation 5 Other Specify: 21. Stepature of Funeral Service Licensee Vice	Our I	_	solation Cen	Parkesb	3.				
	23a. Part I. Enter the disease, or complications that failure. List only one cause on each line. Immediate Cause (Final disease a. Atheroscl	caused the death. Do not e	enter the mode of dying,	rt Ave., Ba	neral Home, I Itimore MD 21 atory arrest, shock, or heart	Approximate Interval Between Onset and Death				
mair Examiner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.									
cian and rial - tra	d.	9,19a,per 1 #9perFH,G918	h,g918 8-19 ,8/17/2011,	-11 sm WS						
Box 687 death certific he attending p d for use as th nysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yet 1 Live 4 Pre	s, outcome of pregnancy birth 2 gnant at time of death 5 nown	Fetal death 3 Other (Specify)	Ectopic pregnancy	23d. Date of de Month	livery Day Year				
P.O. es that the gned by be detach	Part II. Other significant conditions contributing	to death but not resulting in	n the underlying cause gi	1	a. Was an 24b. We	te to the cause of death? Probably 4 Unknown re autopsy findings available r to completion of cause of				
I Records, In: The law require Trifficate has been si Or, page 2 should b Completed	25. Was case referred to medical		26.Place	of Death (Check only one	performed? dea Yes 2 No 1					
Ç.∰. ≱.∄ E	1 Natural 5 Pending Investigation 2 Souicide 6 Could not be determined (Specific Natural Property of Natural 2 Pending Investigation 28e. Pla	th, Day,Year) Ice of Injury - At home, farm	ne of Injury 28c. Injury	es 2 No illding, etc. 28f. Loc	escribe how injury occurred	Other: or Rural Route Number, City				
To the Hospi within 24 hou Fo the Funer completely fil	4 Homicide determined (Specify) 29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
16	29b. Signature and title of certifier 30. Name and address of person who completed ca	ise of death (flow 02s)	29c, License O.C.N		29d. Date signed July 29, 2011	(Month, Day, Year)				
	Donna M. Vincenti, MD Assistant	Medical Examiner	- 4	Street, Baltimore, N	MD 21223					
Registrar HMH 17 Rev 1/2001 CME 2006	AUG 1 2 2011		parle							

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST Physician/ BOOTH 2011 6:00 P.M RUTH Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months (Month, Day, Yea Maryland Director 87 218-12-4486 June Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Harford Bel Air Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral 2060 Rainier Avenue 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ŏ 1 Never Married 2 Married ģ permit. Page 1 and 2 should be filed within 72 hours after Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Automobile Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elmer C. Sauerhoff Ellen P. Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forrest G. Booth MD, 21015 Son 2060 Rainier Avenue BelAir, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State 1 🐰 Burial 2 🗌 Cremation 3 🗌 Removal from State 8-11-2011 Balto. Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Yes 1 Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After t injury work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide determined 24 hours a Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 33227 255 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD 21014 BEL AIR, MD. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ GWENDOLYN MEDILL BRUGGMAN 11:00P M August Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County Towson GREATER BALTIMORE MEDICAL CENTER Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months 214-24-8503 **Director** 1 □ M 2**X** F Jan 22, 1927 Maryland Usual Residence of Deceden an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 ☐ Yes 2 🛱 No Maryland | Baltimore County Lutherville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USA 21.093 405 Brightwood Club Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 X Married 1 Yes 2 X No within 72 hours after Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) the Own Residence Homemaker other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ပ Bessie Gwendolyn Mylander Medi11 Herbert William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10124 Falls Road, Lutherville, Maryland 21093 Ann B. Stieff (Daughter) of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o once. cemetery, crematory or other place, permit. Page 1 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland Green Mount Crematory 8/12/2011 4 Donation 5 Other (Specify) 21. Signature #uperal \$ 1 100 Martin D. Lawson ²²MTTCHELL WIEDEFELD FUNERAL HOME, IN 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Du-lo or as a consequent e of disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to lor as a conse juence of cause. Enter Underlying Cause (Disease or injury -transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregn. 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day detached for Month in the past 12 month Pregnant at time of death 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 1 Yes 2 No 25. Was cas examiper? 1 Yes Division of Vital 26. Place of Death (Check only one) erred to medical Be Hospital Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: After Natural
Accident injury 5 Pending within 24 hours after death.

To the Funeral Director: At 110/2011 intrudin Investigation the Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined BRIGHTWOOD LUB ame Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dath of body burgers stated D Z 1093 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

te filed (Month, Day, Year) AUG 12 2011 32. Registrar's Signature

Bruce Rosenberg,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

29b. Signatur

21 West Road, Suite 100,

D24121

29d. Date signed (Month, Day, Year)

Towson, Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25750 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2011 9:09 Pм Pamela Ware Barclay Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12539 Carrington Hill Drive Gaithersburg Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 💢 Months Hours January 26, 1949 Washington, D.C. Director 215-54-5473 62 Usual Residence of Decedent fshow 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a Funeral 20878 12539 Carrington Hill Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🛣 No 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Director of the Center for Hospital Services College (1-4 or 5+) 5+ Elementary/Seconday (0-12) State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Ware Barclay Kathryn Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12539 Carrington Hill Drive, Gaithersburg, MD 20878 Kathryn Abbett /Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I Important: If ite any injury or ot 1 🗌 Burial 2 ី Cremation 3 🗌 Removal from State August 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 2011 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home Rockville, RODERT A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Migelette DAMAN M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Non Squamous Cell Lung Cancer with Metastases Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No certificate Be Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D37142 August 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, MD 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State Registrar AUG 1

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ΪΌ. 20 I 1 9:35 Keghanoush Boyajian August A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care Bethesda 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday **Funeral** November 20, Months Days Hours Min 1 □ M 2 💢 F Syria 1929 81 **Director** 253-98-5093 Usual Residence of Decedent 28a-f show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Directo 1 Yes 2 X No Bethesda Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 20817 6530 Democracy Blvd Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Fashion Designer/Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Joseph Sanoussian Azniv Sanoussian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42963 Golfview Drive, South Riding, Virginia 20152 Maggie Myers / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 20c. Location - City or Town, State 12, 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Rockville, Maryland Parklawn Memorial Park 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fun all Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. DAMA M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final P y ician/ Aspiration Pneumonia Week disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Years Dementia Sequentially list conditions Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year for Month Dav Pregnant at time of death pau 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🖸 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Accident filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

5

Sankaran Nayar, MD

AUG 1 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

D17874

3717 38th Avenue, Brentwood, Maryland 20722

August 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 2:00 Physician/ Carson, Baxter Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Conversity of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Year) 25,1930 1**X** M 2 □ F Guntry) Illinois 320-24-3376 80 September Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location and Mental Hygiene. is matural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a, State with the Maryland Director Berlin Md. Worcester 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21811 37 Nottingham Lane death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after White Yes 2 XNo Specify If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry during most of working within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Meat Cutter 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Velma A. Custer Charles K. Baxter pe other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1839 Church Road, Dundalk, Md. 21222 Fred Baxter Son 20b. Place of Disposition (Name of cemetery, crematory or other place) August 16, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State injury or Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 2011 ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A 7110 Sollers Point Road, Dundalk, Md Signature of 21222 Dundalk, Md. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myelogenous disease or condition A cute Medical resulting in death) 7 months Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Exami requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Year Pregnant at time of death by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed I page 2 should be det þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? 2 🗌 No After this certificate I 1 Yes Yes Hospital or Attending Physician: 1
 24 hours after death.
 Funeral Director: After this certifica 26. Place of Death (Check only one) funeral director, 25. Was case referred medica Be examiner? Other: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Manuer of Death 1 V Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accider
☐ Suicide Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier P24 354 11,2011 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, MD Norsworth 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

		-	State of Maryland State of Maryland Registrar		irtment of H tificate of D			ene g. No. 2 N I	25753
	Physicia	n/	Decedent's Name (First, Middle, Last) Kum Sun Chu				2. Date of Death August		3. Time of Death 8:20 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice		4b. City, Town, or Colu	Location of Death Imbia	August	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 $ otin{F} $	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) March		rthplace (State or Foreign Suntry) Orea
	aryland a-f show fied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City MD Howard	, Town or Loc E 11ico	ation tt City				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ith the Ma 23a or 28 st be notii	Funeral Director	10e. Street and Number 9067 Northfield Road		10f. Zip Code 21042	2.	10	Og. Citizen of What C	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give	Н	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🌠 No	spanic Origin? (Spe n, Mexican, Puerto		14. Race - Ame Black, White Specify: Ko	te, etc.
Maryland 21215-0036	nin 72 hours ne. h an "natura e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Deced (Give H	ent's Usual Occupa ind of work done d O NOT use retired) Siness Ow:	ation uring most of worki	ng	16b. Kind of Business Deli/Gro	Industry
and 21	be filed with ental Hygier ked other t c event, th	o l	10 17. Father's Name (First, Middle, Last) UNK	Dus	siness ow.	18. Mother's Name	e (First, Middle, Ma		
, Maryl	1 and 2 should of Health and Me item 27 is mar other traumati		19a. Informant's Name/Relationship (Type, Print) Sheena Kwon (Daughter)		g Address (Street a Northfi		Route Number, C Ellicot	City or Town, State, Z Ct City, M	D 21042
Baltimore,	Page 1 ar tment of He tant: If iter jury or oth		1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	emetery, cren idowria		ial Park	8/10/1	Elkridge,	MD
22. Name and Address of Facility Gary L. Kaufman Fu 7025 Washington B 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.							neral Hom d., Elki	ne at MMP, cidge, MD	Inc. 21075
	hysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that called the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the death shock)	FIBR	ILLIATIO	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death 5 4 4 4 5
0	cate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of the consequence						
P.O. Box 68760	ath certifii attending for use as	Ĭ.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	tal death 3 Ectopic pregnancy				23d. Date of d	elivery Day Year
ls, P.O	requires that the der been signed by the s should be detached	ed by Pł	Part II. Other significant conditions contributing to death but not result 5760 PBR 0515	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba		o the cause of death? Probably 4 🗆 Unknown
Division of Vital Records,	sician: The law req s certificate has bec lirector, page 2 sho	Completed by	DIABETES				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of es 2 No
f Vital	Physician: The lav r this certificate has aral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 2 27. Manner of Death 28a. Date of injury	ER/Outpatier	Othe	4 L. Nursing Ho	me 5 Resider	nce 6 X Other (Spe	city) HOSPICE
sion o	spital or Attending Phours after death. eral Director: After th	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	injury	M 1 □	? Yes 2 \(\sum \) No	28d. Describe how	eet and Number or R	ural Route Number,
Div	ospital or i hours after neral Dire d filled in b	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowle				e(s) and manner as s		
(Check only one) 3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29c. License number							e, and due to the c	eause(s) and manner a	s stated. th, Day, Year)
	5		30. Name and address of person who completed cause of death (Item	23a) (Type, F	rint)	4345	201-1-	August	8,2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MD 6336 CEDAR LANE COLUMBIA, ME State Registrar 31. Date filed (Month, Par Year 2 2011 32. Segistrar's Signature). Spans							COLUM	USIA; M.	0 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CORNE/IUS Physician/ WILHELM Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7 MARYOUIL RA BACTIMORE BACTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days New York 1 🛛 M 2 🗆 F Min. 10/22/1928 Director 099-20-4649 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 387 Marydell Road 21229 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Transit Worker City Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicolena Simmons Cornelius, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgianna K. Cornelius / Wife 387 Marydell Road, Baltimore, MD 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 08/11/2011 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ KMKN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month 4 Pregnant
9 Unknown Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown P.O. been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by An/ My Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has , page 2 autopsy : After this certifica e funeral director, r 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 \(\to\) Nursing Home 5 Residence 6 \(\to\) Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fur 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Loch WAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 55 PM Sherman V. Dawson Jr. Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Square Baltimore Kastdale 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Month, Day, Year, April 20 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 219-32-3156 **Funeral** 1 🛛 M 2 🗆 F Months Hours ,1936 75 **Director** Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Essex MD Baltimore 1 Yes 2 No 10f. Zip Code 21221 10g. Citizen of What Country? 10e. Street and Number Funeral 617 Mace Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Beth Steel Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phaller ၉ Catherine Sherman V. Dawson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 617 Mace Avenue Baltimore MD 21221 /wife Myrna Dawson timore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 XBurial 2 Cremation 3 Removal from State Oak Lawn Cemetery 8/12/11 Baltimore MD 4 ☐ Donatien 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. Bai Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or compite ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ ancer disease or condition Medical resulting in death) Que to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Other (specify) Pregnant at time of death 9 Unknown 1 Yes 2 Unknown cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 \square No 3 \square Probably 4 \square Unknown 1 🗹 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie August 8, 2011 070229 Danna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

8

State

31. Date filed (Month, Day, Year)

AUG 1

2 2011

NPIRMON

11-05799	
Dominic Ford	

Dominic Ford	1- For State Registrar	/ Department of Certificate of	Death	rgiene Reg. No.	2011 25756
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Dominic De Sales Ford, Sr.			2. Date of Death Month Day August 2, 2011	3. Time of Death 1410 hrs
	Facility Name (if not institution, give street and number St. Agnes Hospital	r) 4	b. City, Town, or Location of Death Baltimore		. County of Death
Funeral Director		ge (In yrs. last birthday) 19 Yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/ June 13,	DD/YYYY) 9. Birthplace (State or Foreign Matawyd) 2nd
w	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on		10d. Inside City Limits
and fahow a	Maryland Baltimore	Baltimor			1 Yes XX No
n the Maryland 3a or 28a-f sho otified at once	10e. Street and Number 2822 Illinois Ave.		10f. Zip Code 21227		zen of What Country? ted STates
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury, or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces 1 Yes 2 3 Widowed 4 Divorced or Dates:	? 2 ÄÄNo	s Decedent of Hispanic Origin? (Spies, specify Cuban, Mexican, Puerto I	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0036 led within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or	during mo	's Usual Occupation (Give kind of working life. DO NOT use retired times to Electrician	ed)	(ind of Business/Industry
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than marked other than cevent, the Medica	17. Father's Name (First, Middle, Last) Donald E. Ford, Jr.	1	18.Mother's Name Allis	(First, Middle, Maiden on M. Blan	Surname) k
MD 21 and 2 should alth and Me an 27 is ma anumatic ev	19a. Informant's Name/Relationship (Type, Print) Allison M. Ford / Mother	19b. Mailing 2822	Address (Street and Number or R Illinois Ave, Bal	ural Route Number, Ci timore,Mar	ity or Town, State, Zip Code) yland, 21227
Baltimore, Normit. Pages 1 and Department of Health Important: If item injury, or other transitiury, or other transitury, or other transitiury, or other transitury, or other tr	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from S 4 Donation 5 Other Specify:	crematory or oth Meadowridg	e Memorial 8/8/	2011 E1	Location - City or Town, State kridge, Maryland
Balt permit. Departt Import	21. Signature of F	72	50 Washington B1	vd.,Elkrid	an Tunera Mome, nc ge,Maryland,21075
Physician /Medical Examiner		e Intoxicatio		respiratory arrest, sho	Approximate Interval Between Onset and Death
Mar.	or condition resulting in death) Due to (or as a consider of the conditions, b.	sequence of):			
niner	if any, leading to immediate Due to (or as a conscause. Enter Underlying Cause	sequence of):			
0, e be executed sistian and burial - transit edical Examiner	events resulting in death) Last Due to (or as a constitution) d.	sequence of):			
O, e be exec ysician ar burial - tr			per me,g918 8-22		
D. Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	A T Van 2 No 0 T Hekenye	2 Fel	al death 3 Ectopic pregnal	1-0	d. Date of delivery Month Day Year
P.O. Bo s that the de- gned by the s e detached fi by Phys	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical E				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal Rectant The certifical cector, pa	25. Was case referred to medical examiner?		26 Place of Death (Check of	only one)	
of Vid g Physic fer this eral dire	examiner? 1 V Yes 2 No Hospital: 1 Inpati 27. Manner of Death 28a. Date of In (Month, Day,			g Home 5 Reside	ence 6 Other:
Division of Spiral or Attending thours after death. Sueral Director: After a filled in by the function: Certification:	Natural 5 Pending Investigation fd 8-1-	-11 fd 1628 Injury - At home, farm, stree	hrs 1 Yes 2 X No	Unknown 28f. Location (Street a	and Number or Rural Route Number, City 822 III inois Ave.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filted in by the edical Certificatif	4 Homicide determined (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of received the control of the	Residence my knowledge, death occur	red at the time, date and place, and	due to the cause(s) ar	nd manner as stated.
To the How within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examiner and manner stated 29b. Signature and title of certifier		ion, in my opinion, death occurred a 29c. License number		Date signed (Month, Day, Year)
	Hanself Virthall, MD		O.C.M.E.		gust 3, 2011
8	30. Name and address of person who completed cause of Pamera E. Southall, MD Assistant Med		W. Baltimore Street, Baltin	more, MD 21223	
State	31. Date filed (Month, Day, Year) 32 Registr	ar's Signature	Kel		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 8:51 M Isabelle Margaret Fox Medical 4a. Facility Name (if not institution, give street and numbe 4c. County of Death Examiner or Location of Death HOSPITAL TNES BALTIMORE n/a 5. Social Security Number 8. Date of Birth (Month, Day, Year) 3 . 23 . 1929 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Min. 220-20-4297 Director 82 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's Hollywood 1 🗌 Yes 2 ဳ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20636 24300 McIntosh Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Daniel A. Lennon Hannah Doherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trat Christian Fox / Daughter 211 South Rolling Road, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) New Cathdral Ceme. 8/12/2011 Baltimore, Maryland re of Funeral Service Licensee Hubbard Funeral Home, Inc. 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) moundes Medical Due to (or as a consequence of): Examiner 2 days We worker See that findly flat our witting a Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached fi 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ဂ္ 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 81 7 H72243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Si Caton Mre, Balfinere, MD 21229

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August 11, Year 2011 Physician/ 12:15 NPM Fish Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Transitions Nursing Home Carroll Sykesville If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Age (In vrs. last birthday) Days Min (Month, Day, Yea Oct 18 Country) Maryland 1 M 2 X 70 1940 Director 218-36-9297 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Carroll Sykesville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 21784 7309 2nd Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Edwin Clarke Elizabeth Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent DePaul Fish /Son 1233 Cleveland Street Baltimore, MD 21230 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 K Cremation 3 Removal from State Aug 11 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives Hackemon Kelbocca 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immedicause. Enter Underlying Exam the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death i signed by the at Id be detached fo 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be 6 Other: 1 🗌 Yes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 27. Manner eath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident
Suicide 1 Tyes 2 🗌 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 🗓 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Malen In duy

Westmenta MD 21157

permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meany injury or other Physician/ Medical **Examiner** Examine

Physician/

Examiner

Funeral

Director

28a-f shov

ms 23a or 28a-f sho must be notified at

other traumatic event, the Medical Examiner

Completed by Funeral Director

Be

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should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

Medical

the attending physician and hed for use as the burial-transit Division of Vital Records, P.O. Box 68760 this certificate has been signed by the rail director, page 2 should be detached

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after decth.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

edical		₫ d					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year		
ed by P	Part II. Other significant conditions of Aspiration PA	contributing to death but not resulting in the underly	ring cause given in Part I.		cco use contribute to the cause of death?		
Complet	Decubitus u	ilies		24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 No		
Re	25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)			
0	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 [ome 5 🗌 Residence	6 Other (Specify)			
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1 ☐ Yes 2 ☐ No	jury occurred			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ctory, office 28f. Location (St. City or Town		and Number or Rural Route Number, ate)		
Medical	(Check 2 Medical Exam	vsician: To the best of my knowledge, death occurrence: On the basis of examination and/or investigationse Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause(s) and manner stated		
	29b. Signature and title of certifier	1	29c. License number	29d.	Date signed (Month, Day, Year)		
	12 Jan	MO	P25712		8/10/11		
		completed cause of death (Item 23a) (Type, Print)		1			
	BRYON -	TSENG MD 10 N	GREENE ST	r. BALT	IMORE MD 21202		

3

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me g919, 9-1-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ AUGUST 2011 Helen T. Gahm 8:07 P Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 82 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Pennsylvania 1 □ M 2 🔀 F Months 220-24-7637 May Director Usual Residence of Decedent shov 10d Inside City Limits or 28a-f shove notified at 10c. City, Town or Location 10a. State Director Parkville Baltimore MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ed other than "natural", or items 23a or event, the Medical Examiner must be Completed by Funeral 21234 3 Joppa Ridge Circle Apt.2A USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: 3X Widowed 4 □ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) At Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic en Anna Tippman William Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4110 Walther Avenue-Baltimore, Maryland 21236 Matthew Gahm-son # 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Dulaney Valley Timonium, Maryland Aug.10,2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequen of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events CERTIFICATION resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 1 Live Birth
4 Pregnant a
9 Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by intection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number State Registrar

DHMH 17 Rev 7/2009

GINA Teresa 11-05858 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month **Medical Examiner** 0005 hrs e resa August 5, 2011 4a. Facility Name (if not institution, give street and number) tc. County of Death 4b. City. Town, or Location of Death 195 South at Exit 49A **Baltimore Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Director Months Days Hours -2812 Country) / / / 2 V F Usual Residence of Decedent IOc. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No remit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland epartment of Health and Mental Hygiene.

nportant: If item 27 is marked other than "matural", or items 23a or 28a-f sho Director 10e. Street and Number 10a, Citizen of What Country? 10f. Zip Code 151 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Yes Dack 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 27 is marked other than "natur umatic event, the Medical Exam Completed during most of working life. DO NOT use retired) OF Elementary/Secondary (0-12) College (1-4 or 5+) 12 House ree MOIP of Health and Mental Hygiene.

If item 27 is marked other th 17 Father's Name (First Middle Last) 18.Mother's Name (First, Middle, Maiden Surname) ackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD - itus band mid HILL Are APTZ Balgo, md, 21217 enward \rightarrow 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8-12 tone ville Cremator Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License Fred HILTON · Balto, md. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical signed by the attending physician be detached for use as the burial UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 ✓ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient Other₄ Nursing Home 5 Residence 6 Other: Scene DOA ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) Aug 5, 2011 Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification Subject ejected from motor scooter in vehicular 1 Natural Division Pending 1 Yes 2 V No in by the collision 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 195 South at Exit 49A, Baltimore, MD filled determined (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attendin within 24 hours after death.

To the Funeral Director:

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day, Year) State Registrar 2011

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

OCME

ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 5, 2011

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	•	State Registrar				tificate of D			Reg. No	-	11	25762
Division	,	1. Decedent's Name (First, Middle, L	.ast)					2. Date of Dea	ath Da	20	Year	3. Time of Death
Physicia Medic		Kathleen	Marie	Gril1	-			August		20	11	6:20 A M
Examin		4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town, or I	Location of Death		4c.	. County c	of Death	
<i>'</i>		Shady Grove Adv					kville			Mo		mery
Funeral Director		378-56 - 1008	. Sex 1 □ M 2 🕅 F	ge (In yrs. last bir 60	thday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day March		51	Coun	place (State or Foreign htry) higan
how at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation					1	10d. Inside City Limits
Marylar 28a-f sl otified	irecto	MD Montg	omery	,,,		Montgomer	y Villag	e				1 ☐ Yes 2 🛣 No
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 13 Sparrow Vall	ey Ct.			10f. Zip Code	886			tizen of W nited		
items		11. Marital Status	12. Was Decedent Armed Forces?		13. V	as Decedent of His Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No- Rican, etc.)			- Americ	can Indian,
ırs after o ıral", or I Examir	ed by	1 🕅 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 L If Yes, Give Year or Dates.	No		☐ Yes 2x No		. ,		Specify:		Thite
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)			(Give k	ent's Usual Occupa ind of work done du NOT use retired)		ing	Vet	and of Bus	S	
with ygien her th			5+		lmin	istrator			Adn	ninis	trat	ion
d be filed Mental Harked oth	To Be	17. Father's Name (First, Middle, Las William	Cooper	Gri11			18. Mother's Nam Mary	e (First, Middle, Ann			Beer	man
2 should lith and N 27 is ma		19a. Informant's Name/Relationship Judy B. Grill S				g Address <i>(Street ar</i> 7 Sparro w					ate, Zip (
1 and of Hea item othe		20a. Method of Disposition		20b. Place of	of Dispos	sition (Name of eatory or other place		Date			City or To	own, State
Page nent c ant; If		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		(Ukn)	лу, степ	atory or ether place	(Ukn)		(Uk r	r) Si.	lver	Spring,MD
permit. Departr Imports any inji		21. Signature of Funeral Service Lice	ensee	01839	22 R Q	Name and Address app Funer 33 Gist A	al and C	rematio ver Spr	n Se	ervic MD	es 20)910
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 D Fetal deat at time of death		Ectopic pregnancy Other (specify)	/			23d. Date Mor		very Day Year
requires that the de been signed by the should be detached	Ϋ́Р	Part II. Other significant conditions	s contributing to death	but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did t	obacco	use contri	bute to t	the cause of death?
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ending Feath.	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation			Time of injury	28c. Injury work? M 1 🗆 `		28d. Describe I	how injur	y occurre	d	
al or Atte s after de il Directo ed in by t		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	28e. Place of In	jury - At home, fa tc. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (S City or Tov			r or Rura	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Exa	Physician: To the best of aminer: On the basis of lurse Practioner: To the	examination and/	or invest	igation, in my opinior	n, death occurred a	t the time, date a	and place	e, and due	to the ca	ause(s) and manner stated.
To th Withir To th соттр	2	29b. Signature and title of certifier			<u></u>	29c. License			00-l D-	*	/8.6 +b	Day, Year)
		Mike MA		mo			144		5	3/8/	11	
12+1		30. Name and address of person wh	no completed cause of a	death (Item 23a)	(Type, P	ter Drive	e, Rock	wille,	Mai	rV lai	-ol	20850

State Registrar 31. Date filed (Month, Day, Year)
AUG 1 2 2011

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month РМ 2011 8:05 Mary Louise George August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 9432 Birdhouse Circle Columbia Social Security Number Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Functal** (Month, Day, Year) Hours 152-48-6463 **Director** 1 🗆 M 2 🖾 F 57 Sept 30, 1953 New York Usual Residence of Deceden show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 XNo Maryland Columbia Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 9432 Birdhouse Circle 21046 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 0 þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education other Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ၉ John Lynch Marv Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other trai 9432 Birdhouse Circle Columbia, MD 21046 Philip G. George / Husband 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury of once. 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/15/2011 Woodbine, Maryland Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, M protte MD 20129 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Multiforme Glioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atter should be detached for Month Day Year 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sral Director: After this certificate has filled in by the funeral director, page 2 and an extension of the funeral director, page 2 and an extension of the funeral director. autonsv 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other မ 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I work? 1 Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar Tens

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N.

(Check

only one)

John (Laterra

Wolfe St. Baltimore, MD 21287

mo Phi

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D37018

29d. Date signed (Month. Dav. Year) 08/12/2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20 Yes 10:56P Ruby He1m Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Golden Living Center Westminster Social Security Number 9. Birthplace (State or Foreign Country) VA If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Days Min Months Hours 1 M 2 X 03-10-1916 231-05-6987 Director 95 Jsual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2XX No Carroll Finksburg 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 3806 Freida Drive 21408 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 0 1 Never Married 2 Married Completed by be filed within 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 ☐ Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Manufacturer Factory Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Albert Harvy Wimmer Lydia Palmer Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Donald Ferguson - grandson 3806 Freida Drive, Finksburg, Maryland 21408 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State Balt.-Wash. Crematory 08-03-11 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature of Funeral Service Licensee MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a, Part 1 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cau Immediate Cause (Final Onset and Death Physician/ TUN disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician are as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year 4 Pregnant at time of death 9 Unknown detached the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aligust 4 Day 2011 Year 12:29 A M George John Hipple Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Howard Gilchrist Hospice Care Columbia 7. Age (In yrs. last birthday) Social Security Number 220 60 7651 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month, Day, Year) Country) Washington, **Director** July Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Howard 1 ☐ Yes ※XX No Elkridge 10f. Zip Code 10e. Street and Number 6423 Woodburn Ave. 10g. Citizen of What Country? United States 21075 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc ģ 1 Never Married 2 X Married 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. ₩ho<u>l</u>esale Liquor Elementary/Seconday (0-12) College (1-4 or 5+) Merchandiser Industry Be 17. Father's Name *(First, Middle, Last)* George John Irvin 18. Mother's Name (First, Middle, Maiden Surname) ൧ Anita L. Layton permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic o traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie M. Hipple/ Wife 6423 Woodburn Ave, Elkridge, Maryland, 21075 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 8/8/2011 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral HOme, Inc. 7250 Washington Blvd., Elkridge, MAryland, 20175 ru 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATORENAL SUNDROME
Due to (or as a consequence of): Physician/ WEEKS disease or condition Medical resulting in death) Examiner COLON DANCE JULY 2009 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examin spital or Attending Physician: The law requires that the death certificate be executed cours after death.

In a law of the this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No HOSPICE မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 1 🖄 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the best of provided and death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 164395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 BEDAR LANE COUMBIA, MB 21044 DANIEUE DOBERMAN, MO

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month Day,

32. Registrar's Sigrature

			1 - State Amend Item 2	State of M 25 per me ,	aryland g 918,0	/ Depa 8/31/	rtment of F	lealth and Death	Mental Hy	giene Reg. N 20		25767	
	Physicia	n/	Decedent's Name (First, Middle, La Chun Bo Hong	•					Date of Dea Month	Day	2011	3. Time of Death	
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	Funeral Director		5. Social Security Number 6. S 217–88–0317	Sex 7. Ag	e (In yrs. last .	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year) 43	9. Birth	place (State or Foreign	
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	th with ms 23a must t	Funeral Director	39 Malton Court	10 Was Dage days (Tyran in LLC	10.14		L234	nosify Von or No		U.S.A.		
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	 11. Marital Status 1 □ Never Married 2XXMarried 3 □ Widowed 4 □ Divorced 	12. Was Decedent B Armed Forces? 1 Yes 2 If Yes, Give X Year or Dates.		If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☐XNo	n, Mexican, Puerl	o Rican, etc.)	В	lace - Americ lack, White, hify: Kor	etc.	
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ary	d 2 should bath and Me 27 is mark	3	19a. Informant's Name/Relationship (Į.		g Address (Street a	and Number or Ru					
	ge 1 and 2 s t of Health If item 27 or other tr		Jung H. Hong (Williams) 20a. Method of Disposition	ife)	20h Plac		Malton Co	ourt Pa	rkville,		and 21		
Baltimore,			1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		cem	etery, crem	atory or other place					Maryland	
Balt	permit. Page Department (Important: If any injury or once.	1/250 Washington F							uneral H	ome at	MMP,	Inc. 21075	
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9	certificate be nding physicia use as the bur	edical		l d									
		by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	etal death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year		
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on of	nding ath. r: After e funer	icate	1 Autural 5 Pending 2 Accident Investigation	(Month, Day	(, Year)	injury	28c. Injury work M1	y at ? Yes 2 □ No	28d. Describe h	now injury occi	urred		
DIVISION	I or Atte after de Directo	Certificate:	3 Suicide 6 Could not 4 Homicide determined		iry - At home (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow		nber or Rura	I Route Number,	
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	North Com		29b. Signature and title of certifier.	9. A	hm	0	29c. License		0	29d. Date sign	ned (Month,	7, 2011	
	5		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, Pr	lowing Ch	Ances	TRAPT B	ALTINUE	ze Mi	7, 2011	
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	Funeral Director		5. Social Security Number 6. Sec. 217–90–3400		s. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth $Dec \ \ 16,$	1965 9. Bird	thplace (State or Foreign Tryland
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard		10c. City, Town or Location Columbia					10d. Inside City Limits 1 ☐ Yes 2 🖁 No
	vith the Ma 23a or 28 st be noti	eral Dire	10e. Street and Number 9733 Soft Water	Way		10f. Zip Code 21046		10	Og. Citizen of What Co USA	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: b 3	
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imore	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	cemetery, cre	osition (Name of matory or other place cremat	orv 8-1	2-11	20c. Location - City or Beltsville	<u> </u>
Balt	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Signature of Funeral Service Licensee 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								717 Green timore, MD	Pastures Dr. 21286
- F	Physician/ Medical	26 4	23a. Part 1 Enter the disease, or come shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line. a. Due to (or as a cons	se P					Approximate Interval Between Onset and Death
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part II. Other significant conditions Part II. Other significant condition							Yes 2 No	28f. Location (Str City or Town	reet and Number or Ro , State)	ural Route Number,
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	To the within 2 To the comple	-	29b. Signature and title of certifier	skill use	2	29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print) How	oard Co	unty C	reneral	Hogital 21045
	Sta Registr		31. Date filed (Month, Day, Year) AIIG 1 2 20	32 Registrar's Si	gnature	arker	J. C.	1	- 4 (as	

11-05906

amend items 23a,27,28a,b,d-f per me g919 9-29-11 vt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cecilia Harvey State of Maryland / Department of Health and Mental Hygiene 25769 2011 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ CeCelia (Marion Harvey 1507 hrs Medical Examiner August 6, 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City Town or Location of Death University Hospital Baltimore If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 216-84-4075 41 Months 3-14-1970 Country) MD Director 1 M 2 X F Usual Residence of Decedent any 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location MD Baltimore 1 X Yes 2 No or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-fabe injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 1119 Ostend Street USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes Black 3 Widowed 4 Divorced Yes, Give Yee 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Camden Yards Salesperson MD 21215-0036 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Foy Harvey Sr. Marion Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2721 Coldstream Way Balto MD 21234 Mashelle Tillman - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Mount Carmel Cem 8-13-201 Dundalk MD Donation 5 Other Specify: 22 Name and Address of Facility Phillip A Weatherford FSPA 21. Signature of Funeral Service Licensee E Oliver St Baltimore MD Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Complications of Chronic Narcotism** Approximate Interval **Physician** Between Onset and /Medical Death a Fentanyl Intexication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED #19a,perFH,G918,8/12/2011,WS g918 8-19-11,27,28a-f,per me attending physician a for use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Cardiomegaly with bridging of left anterior descending Completed 24b. Were autopsy findings available 24a. Was an artery prior to completion of cause of autopsy certificate has performed? death? ✔ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: After this ဥ 1 🗸 Yes No funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural s after death.

A Director: A ed in by the fu 1 Yes 2X No Pending fd 8-3-11 fd 4:00pm 2 ___ Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or Rural Route Number, City 3 Suicide Sould not be filled in or Town, State) 1119 W. Ostend St. To the Hospital
within 24 hours a
To the Funeral I determined Residence (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number August 7, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)



32, Registrar's Signature

State Registrar Ana Rubio MD.

31. Date filed (Month, Day, Year,

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

			Plea an State Amend Ite Registraramend #5	se Type or Printend#29perph	nt in Black I aryland (Dep	ndelible inlantage	k. Ensure A lealth and N	All Copies A	re Legible ∰	9.
	Physicia	n/	 Decedent's Name (First, Middle, 	, Last)		rtificate of L	Death	2. Date of Death		3. Time of Death
Jun	Medic		James	Hay	res			August 1		2355 м
	Examin			ton Medical		Ft. Wa	r Location of Death shington			George's
	Funeral Director		236-68- 3958	6. Sex 1 M 2 F 7. Age	e (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yei Jan 3, 1	9. E 945 We	Birthplace (State or Foreign Country) est Virginia
	nd ihow at	ا د	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	vlaryla 18a-fs tified	rect	MD Princ	e George's	Ft. Wash	ington				1 ☐ Yes 2 🔀 No
	h the la	al Di	10e. Street and Number			10f. Zip Code			. Citizen of What	Country?
	ath wit	Funeral Director	9114 Tandem Dri	12. Was Decedent E	verin IIS 13	Was Decedent of H	Ispanic Origin? (Spe		ISA	nerican Indian,
36	after dea Il", or ite xaminer	by	1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	ried Armed Forces? 1 🛣 Yes 2 🗌 If Yes, Give	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, Wh	
9	hours natura ical E	letec	15. Deceden	Year or Dates.	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Busines	
21215-0036	ithin 72 l ene. r than "r the Med	Completed	(Specify only highest Elementary/Seconday (0-12)	st grade completed) College (1-4 or 5	+) life. L	kind of work done come of the		ing	Maintena	
and 2	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "tatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	പ	17. Father's Name (First, Middle, La Sidney Preston	*	<u>'</u>			e (First, Middle, Maid Washingto		
Maryland	should and Me is marl aumati		19a. Informant's Name/Relationsh	nip (Type, Print)				al Route Number, Cit	_	
e, R	and 2 Health em 27 ther tr		Martha Paulette 20a. Method of Disposition	Hayes - Sis	ster 91 20b. Place of Disp			Washingto	c. Location - City	20744
Baltimore,	permit. Page 1: Department of I Important: If it any injury or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Pemoval from State	cemetery, cre	matory or other place Crematori	ne) i	.,	Princeto	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service V	icensee	Q 2	Name and Addres		Seaver Fun 1. Walker		ne ceton, WV 24740
			23a. Part 1 Enter the disease, or shook, or heart failure. List of Immediate Cause (Final	complications that caused nly one cause on each line	the death. Do not en		ng, such as cardiac ft Hip Fr			Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Heat Due to (or as a	a consequence of):	Stron			1.00	7/23///
e.	Examiner	ie.	Sequentially list conditions,	ь. Thron	nbocyt	openia		- Ay	Jon E	7/23 /11
10	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. Left	Hip Fr	acture	Alos	AN M	55921	7/23/11
0			resulting in death) Last	d.	a consequence of):		P	7		
. Box 68760	ath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Cother (specify)	су		23d. Date of Month	delivery Day Year
, P.O.	es that the der signed by the signed be detached		Part II. Other significant conditio	ons contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I. bocytoper	23e. Did tobac		to the cause of death? Probably 4 🔀 Unknown
of Vital Records,	require been si should	Completed by	711001701	CIDINO :				24a, Was an		autopsy findings available
Seco	The law ate has page 2	omo						autopsy performe 1 Yes 2	d? death	to completion of cause of i? Yes 2 \sumbed No
alF	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?				lace of Death (Chec		INOI TO	163 2 110
f Vit	Physic this ce al dire	은	1 X Yes 2 □ No 27. Manner of Death		ent 2 ER/Outpatie		4 □ Nursing H	ome 5 Residenc		A 31
0 0	ding l tth. : After e funer	cate	1 Natural 5 Pending 2 Accident Investig		2011 injury	work work	yat <br Yes 2 ☑ No	Subject exp	osed to hi	gh environmental temperature and
Division	or Atter after dea Director in by the	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be	ry - At home, farm, st	American CD	100 M	28f. Location (Stree City or Town, S	et and Number or State) 9,1,1,4,7 T	Rural Route Number anden Drive and Washington, MD
0,	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of ex	xamination and/or inve	stigation, in my opinio	on, death occurred a	nd due to the cause(at the time, date and p	s) and manner as place, and due to the	stated. ne cause(s) and manner stated.
5	To the vithin comple	Σ	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner: To the	best of my knowledge,	29c. Licens			Date signed (Mo	
			30. Name and address of person v	who completed cause of d	eath (Item 23a) (Type	Print)	exp		921	1
_			Samuel Kle	iman, MD 11	711 Livin		d Ft. Was	shington,	MD 2074	44
	Stat	te	31. Date filed (Month Day, Year)	32. gegistra	Booker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** HULL an 8:00 A M 2011 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner medical BOUGHMUYE Baltimore (eviter If Under 1 Year 8. Date of Birth (Month, Day, Year) curity Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Mayyund Min. Months Days Hours 1 □ M 2 XF 201 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show or items 23a or 28a-f shown in the contract of 1 ☐ Yes 2 No Director MD BOUTH MOTE PIVERNIVE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7025 21208 A)(I Deer Field Road Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give! Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after dee Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examination once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ. Specify Specify: 61001 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cotasha miller umother Field PIVESU Ve WD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 24 athedra Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley - ASKHON FUNETal Rd 21222 Home 21. 11000 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 14hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 14115 CHOMO OMMINIONAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2 No 1 ☐ Yes 2 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Paul 301 32. Registrar's State AUG 1 2 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Donartment of Health and Mental Hygiene

Physicia /Medic Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant must be neithful at ognee.

CLifford

Hodge SR. cliffo Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar DHMH 17 Rev 1/2001

	For State Of Maryland / L	Certificate of		Reg.	2011	25772
n	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
il	Clifford Gaston Hodge		Leasting of Dooth	8 /	O ZOII 4c. County of Death	425 AN
r	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUASE HOSPITAL CENT.		r Location of Death sedale		Balti	
	5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	pplace (State or Foreig
	200 01 1074	Yrs. Months Days	Hours Min.	(Month, Day, Ye May 10, 1	933	nplace (State or Foreig untry) VC
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
TO	MD Baltimore		lle River			1 □Yes 2 XN
lrec	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cou	intry?
ral L	352 Grovethorne Road	212	20		USA	
nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
Dy F	1 Never Married	1 □Yes 2¥ No	Specify:			hite
eg G	15. Decedent's Education 16a.	Decedent's Usual Occup	pation	16b	o. Kind of Business/li	ndustry
Completed by Funeral Director	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)	g		
5	12th	Plate Mill			Beth St	eel
ge	17. Father's Name (First, Middle, Last) Thomas G. Hodge		18. Mother's Name	(First, Middle, Maid King	den Surname)	
2 │	-	. Mailing Address (Street			itu ar Taum Ctata 7	in Code)
	Peggy Hodge /wife	352 Grove				
	20a. Method of Disposition 20b. Place of cemeter	Disposition (Name of	Da Da	ite 200	. Location - City or T	own, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holl	y, crematory or other place Ly Hill Ce				
	21. Signature of Funeral Service Licensee	22. Name and Addre	ess of Facility 300	Mace A	ve. Balt	o. MD
-	fales fly Convelly n	Connel	ly Funer	al Home	of Esse	x 21221
1	23a. Part J. Enter the dise se, of con. cations that caus of the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final		ig, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death) I Schemic b Due to (or as a consequence of the					
		51).				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underfuin, Cause (Lisease or injury that initiated events	of):				
Yall	Cause (Disease or injury that initiated events resulting in death) Last c	-0.				
<u>2</u>	Due to (of as a consequence of	n).				
ealical	d			_		
	IF FEMALE: 23b. Was decedent pregnant in the pact 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	2 □ Estonia arcanona			23d. Date of deli	very
SICIALI/IN	1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _			Month	Day Year
2	9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying eques give	on in Port I	23a Did tahaa	co use contribute to	the cause of death?
2	encephalopathy multip			1 ☐ Yes		
	7)	0.1907	1 41 1000	24a. Was an		opsy findings available
2				autopsy performed	prior to c death?	ompletion of cause of
	25. Was case referred to medical		26. Place of Death	1 □ Yes 2 ☑ (Check only one)	No 1 □Yes	2 □No
2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Our	tpatient 3 DOA Oth	er.		e 6 □Other (Spec	ify)
1	27. Manner of Death 28a. Date of Injury 28b. T 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Ir	ime of 28c. Injur	y at 28	3d. Describe how in	njury occurred	
	2 Accident investigation 3 Suicide 6 Could not be 28 Place of Injury. At home for		Yes 2 □No	V 1 1 10		
5	4 Homicide determined determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, lactory, office	28	City or Town, S	t and Number or Ru tate)	ai Houte Number,
1	29a. Certifier 1 Certifying Physician: To the best of my knowledge	, death occurred at the ti	me, date and place, a	nd due to the caus	e(s) and manner as	stated.
	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	d/or investigation, in my o	ppinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	29b. Signature and title of certifier	29c. Licens		29d.	Date signed (Month	
	1 11		2364		8-10-3	2011
	30. Name and address of person who completed cause of death (Item 23a) (C	170 :2	T - 100 0 -	3 3 3
	DR Devadatta Ashok Sarwate 9000 31. Date filed (Month, Pay, Year) 32. Registrary Signature	OFKANKLIN	square	UK Bal	10 md 2	01601
	31. Date filed (Month, Pay, Year) AUG 1 2 2011 Server 3. Registrary Signature August 2. Augus	te!				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G918 8/19/2011 JH State of Maryland Department of Health and Mental Hygiene Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ 0051 AM MELVIN HOFFMAN 2011 Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death Bultimore Galfimore Hospital N/AD+ KNOWACS HOFFMan, Melvin Baltimore, Maryland 21215-0036 214ª S20 4540 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. 1070471926 84 **Director** Usual Residence of Decedent or 28a-f shov ital Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 905 POINT PLEASANT ROAD 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ should be filed with n and Mental Hygien is marked other th LAWYER LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည DAVID HOFFMAN HILDA KELLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HILDA HOFFMAN/WIFE 905 POINT PLEASANT ROAD, GLEN BURNIE, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 08/11/2011 BNAI ISRAEL CONGR. BALTIMORE, MD 21. Signatur, of Funeral Service Ligense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 🗌 Unknown Division of Vital Records, P.O. Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Alzheimers dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \times No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and of an a control of the sould be a control of within 2 29b. Signature and title of certifier RES-000 AUGUST, 10,204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITAL OF BALTIMORE KARHADKAR, MO SINAI 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N 20 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Stanley Jaskiewicz 10:09 PM 2011 09 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1**XX**M 2 □ F Days Hours 92 Brooklyn, New York 144-10-9127 **1**918 Director Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Parkville Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd. Apt. 1104 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXIIo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify. 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Industry Tailor 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Celica Adam Jaskiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8820 Walther Blvd. Apt. 2505 Parkville, MD 21234 19a. Informant's Name/Relationship (Type, Print) Joseph Jaskiewicz -Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August Department of I Important; If it any injury or or ē 12, cemetery, crematory or other place) Page 1 1XXBurial 2 Cremation 3 Removal from State Calvary Cemetery Paterson, New Jersey 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Finneral Service Licenses

22. Name and Address of Facility
Evans Funeral Chapel & Cremation
8800 Harford Road Parkville, Me

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dementes en Jascu disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed neral Director; After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? 1 Tyes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XIVo 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar

Registrar DHMH 17 Rev 7/2009

State

6701 N. Charles

NV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Ellen Klinefelter 2011 3:17 P.M August 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7 Todd Slope Road Finksburg Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX**F (Month, Day, Ye Hours Min **Director** 217-24-7481 83 Maryland 1928 Mav Usual Residence of Decedent Fshow be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits or items 23a or 28a-1 Maryland Carroll Finksburg 1 Tes 2XXNo 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code Funeral 7 Todd Slope Road 21048 <u>America</u> Was Deced Armed Forces? 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify "natural" Specify: White 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th and Mental Hygier is marked other t Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Harry H. Keller Ethel Garrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Lee Klinefelter (Son) 34 Bosley Ln., Resiterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 12 netery crematory or other place) Faiths Crematory & Chapel 1 Burial 2XXCremation 3 Removal from State AlĬ 2011 4 ☐ Donation 万 ☐ Other (Specify) Manchester, Maryland Signativ e of multeral Service Lic 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 Part . Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Introdiate Cause (Final Physician/ **ASCVD** Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy signed by the a Completed by page 2 should

the Hospital or Attending Physician: The law requires that the death certificate be executed s after death.

I Director: After this certifica ed in by the funeral director, p filled in by

Be မ Certificate:

29a. Certifier

(Check

only one 29b. Signature

AUG 1 2 2011

nd titlevof certifier

in the past 12 months? 1 Yes 2XXNo 9 Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown				Month	Day	Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacco 1 Yes 2	use contribute to		
				24a. Was an autopsy performed?	death?	utopsy findin completion	of cause of
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ [OOA Other: 4 Nursing H	Iome 5XXResidence	6 Other (Spec	cify)	
27. Manner of Death		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur			
4 Homicide determined		ome, farm, street, facto	ry, office	28f. Location (Street an City or Town, State		ıral Route Nu	ımber,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

August 11, 2011

29c. License number D0051924

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Herbert P. Henderson, Jr., M.D., 2973 Manchester Rd., Manchester, MD 21102 31. Date filed (Month, Day, Year,

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARTHA 10 2011 JANE KIELEK AUGUST 11:15a /Medical V 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5 6005 A SHADY SPRING AVENUE ROSEDALE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 7 F 58 Director 02/09/1953 213 62 MARYLAND _031 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Evidical Evertines rules be notified at 08/10/2011 1 ☐ Yes 2 XNo Director MD BALTIMORE ROSEDALE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6005 A SHADY SPRING AVE Funeral 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【XNO Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 「あしがん 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) REGISTERED NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CASMIR KIELEK KING ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if Item 27 Is any Injury or other trau DENISE KIELEK/Daughter 607 SOPWITH DR. APT C. BALTIMORE, MD 21220 Baltimore, Aetha 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2
Cremation 3 ☐ Removal from State METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 8/13/11 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Exanguination** Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** a Duicide * XSang /Medical Due to (or as a consequence of): Examiner Cutting Wounds of the Wrist Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be execu burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 pronths? Yea Month Day 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ sigr 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐Yes 2 ☐No 1 Yes 2 No Physician: 25. Was case referred to medical examiner?
10 Yes 2 □ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \square Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ō After this funeral 27. Manner of Death Subject cut, self 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? or Attending Division 1 Naturai 5 Pending investigation after death. 08/10/2011 11154 M 1 ☐ Yes 2 🔽 No 2 Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 11,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILLP MILITEL GTRIMBLE HILL Therville, Md MU 32. Registrar's Signature State Registrar

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O. Box 68/60	Baltimore	Baltimore, Maryland 21215-0036	المعالج المعالجة المع	
at the death certificate be executed	permit. Page 1	72 hours after death with the Maryland	<i>)</i>	
et by the attending physician and etached for use as the burial-transit on so	Important of the line of the l	Department or Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Physic Med Exam Funera Directo	
Physician/Medical Examiner		To Be Completed by Funeral Director	ical iner	

	_	State Registrar		Cer	tificate of L	Death		Reg. No 20		25777
Physicia Medic		1. Decedent's Name (First, Middle, Last Timothy Buck Lair	•				2. Date of Dea Month August		20 1 1	3. Time of Death 5:45 P. M
Examin		4a. Facility Name (if not institution, give 642 Regester Ave.	street and number)			Location of Death		4c. Count Balti	y of Death more	County
Funeral Director		210-30-4437	ex ☐XM 2 ☐ F 7. Age (In yrs. le 55	ast birthday) Yrs.	thday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) OCT. 25, 1955 9. Birthpl Caustin Ball					place (State or Foreign htm://
vlaryland :8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo		y, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 No
with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 642 Regester Ave.			10f. Zip Code	21212		10g. Citizen of Ur		ntry? States
should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ゑ	11. Marital Status 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 TNo If Yes, Give Year or Dates.	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ack, White,	can Indian, etc. White
in 72 hou e. nan "natu Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	(Give k life, DC	O NOT use retired)	during most of work		16b. Kind of I		
e filed with ntal Hygien ed other the	To Be Co	12 17. Father's Name (First, Middle, Last) Louis Calvin Lair	N/A	L	andscape	Gardener 18. Mother's Name Harriet	e (First, Middle,			caping
and a range of the control of the co		19a. Informant's Name/Relationship (T) Mr. Louis Calvin	vpe, Print) (Brother)		g Address (Street a	and Number or Rura				Code) 11787
Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	S Fure	sition (Name of natory of other place all Chapel ervices, In	and Fri	Date day, 12,2011	Forest	Hill	County) , Maryland
permit. Page 1 a Department of h Important: If its any injury or of		21. Signature of Funeral Service Licens	Jeffrey L.Gair, S	r.03922 0677	Name and Address Proceding All 2325 York	temalityes Road Timo	Funeral a	and Crema Zlamo 2	tion (1093-2	enter, P.A. 215
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MET 1. Enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. Use only one cause on each line. Due to (or as a consequence of):							or respiratory an	est,		Approximate Interval Between Onset and Beath
tificate be executed ng physician and as the burial-transit	cal Examiner	It any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a consequ							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	l death 3	Ectopic pregnanc	Э			ate of deliv	very Day Year
law requires that the death ce has been signed by the attend ie 2 should be detached for us	ρ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to			he cause of death?
The law recate has be page 2 sho	Completed						24a. Was autop perfo 1 Yes		prior to co	opsy findings available ompletion of cause of 2 X No
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ital or Atte urs after de ral Directo lled in by th										l Route Number,
Proceedings of the control of the cause (s) and manner as stated. 29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ause(s) and manner stated. tated.	
To T To T Corr		29b. Signature and title of certifier	HIKLE			6514	J	29d. Date sign	id (Month,	Day, Year)
		Kichard L. +	In the cause of death (Item	23a) (Type, Pi 7505 (Suite 30	12 Tower	ı,Marylan	d_212	04
Stat Registra	e	31. Date filed (Month, Day, Year)	32. Tyletker's Oignat	fure 2	0. 10. 1					

			For State	State of M	aryland		artment of F tificate of F		nd Mental I		001	0.55		
		Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Death		
	Physician/ Medical Howard Louis Levy								Month Augu		Day Year 2011	3:11 P ^M		
1990	Examin		4a. Facility Name (if not institution	give street and number)			4b. City, Town, or	Location of [Death		4c. County of Dea			
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	ith the		10e. Street and Number	2			10f. Zip Code			10g.	. Citizen of What C	ountry?		
	ems;	Funeral	214 Midhurst 1	12. Was Decedent 8	ver in U.S.	13. V	21212 Vas Decedent of Hi	spanic Origin	? (Specify Yes or	No-	U.S.A.	erican Indian,		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	ied Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No		Yes, specify Cuba		Puerto Rican, etc.)		Black, Whi	te, etc. Vhite		
-00	hours natura lical E	lete	15. Deceder	it's Education		16a. Deced	ent's Usual Occup	ation		168	b. Kind of Business			
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lan	should be file and Mental F is marked o raumatic eve		19a. Informant's Name/Relationsh								y or Town, State, Z	ip Code)		
	and 2 s Health s tem 27 s		Robin Prothro	/ Wife	20h Bloo		Midhurst sition (Name of	Road,			MD 21212 c. Location - City of	r Tourn State		
nor			1 ☐ Burial 2 ☐ Cremation 4 ※ Donation 5 ☐ Other (S		cem	etery, cren	natory or other place		Date	Ì	anover, N			
Baltimore,	permit. Page Department of Important: II any injury or once.		21. Signature of Farieral Service I	-1	Alacc						ts Regist			
<u>m</u>	9 9 E E 9) BOK								Hanover	, MD 21076		
			23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final	ply one cause on each line						y arrest,		Approximate Interval Between Onset and Death		
and the	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as	consequen	ce of:	- deg	enc	rann			years		
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e	xamination ar	nd/or invest	igation, in my opinio	n, death occu	irred at the time, da	ate and pl	lace, and due to the	cause(s) and manner stated.		
	within 2 To the comple	ž	only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my kr	nowledge, c	leath occurred at the 29c. License		nd place, and due t		use(s) and manner a Date signed (Mon			
	1		> Agna	entry			1)58	3300	A	rugust	1105 11		
_	Ψ		30. Name and address of person	who completed cause of d		Ba) (Type, P	rint) 5701 N	, a	ronly	So	Taus	anno		
	Stat Registra		31. Date filed (Month, Day, Year) AUG 1 2 2011	32. Registra	ar's Signature	e del								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Month August 8, 8:20 A M Dorothy Marie Lauber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pickersgill Baltimore Towson 8. Date of Birth (Month, Day, May 28, **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) 915 1 🗆 M 2 🗓 F Months Days Maryland **Director** 212-05-2970 96 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 1 Yes 2 X No Maryland Baltimore Towson ritems 23a or iner must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ö ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No "natural" Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 01 Utilities Accountant nt of Health and Mental Hyg : If item 27 is marked othe or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adam Lauber Nettie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 4762 Cambridge Drive, Dunwoody, GA John Philip Lauber/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 4 Depation 5 Other (Specify) Atlantic Crematory 8/10/2011 Glen Burnie, Maryland Bryan W. Cla 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium. MD 21093 Clary ailure. List only one cause o 23a. Part 1. Eyler the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, of heart Immediate C s inal disease or con ition Onset and Death Physician/ Due to (or as a consequence of): DEMENTIA disease or con it is resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregna 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No Month Day Year cate has been signed by the a page 2 should be detached P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, NEMIA 3 ☐ Probably 4 ☐ Unknown 1 Tes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The performed 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 I No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the ! only one) 29b. Signature and title of certifie GRIH CHARLES STREET State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25780 for State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ CLIFTON W. LANHAM, SR. **AUGUST** 6. 12:37 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL GLEN BURNIE 308 MARY LOU AVE. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Birtnpic. Country) **MD Funeral** 1 XX 2 F Months Days Hours Min SEPT 2, 1933 Yrs. **Director** 216.30.8707 77 Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2xx No GLEN BURNIE MD ANNE ARUNDEL 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be a Funeral 308 MARY LOU AVE. 21060 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Vas Deceue... _ Armed Forces? ☐ Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc. by 1 Yes 2 I I Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE 52-56 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **SUPERVISOR** TRANSPORTATION 8 permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLIFTON FRANKLIN LANHAM **EVELYN MARY KING** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 MARY LOU AVE. GLEN BURNIE, MD 21060 PATRICA E. LANHAM WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) MDVETCEM CROWNSVILLE AUG 10, 2011 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) a of Funeral Service Lice FINK FUNERAL HOME, P.A. GREGORY FINA M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Noter the dise shock, or heart failer complication. — aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each Approximate Interval Between 1 Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the detached 9 Unknown er significant conditions cor 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops page 2 perforn this certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home Residence 6 Other (Specify) : After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

DHMH 17 Rev 7/2009

only o 29b. Signat 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard Maxfield 08 August 2011 1639 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2620 Miles Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F 217-34-4880 Director Maryland 03/15/1936 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2620 Miles Avenue U.S.A. 21211 . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stationary 12 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John Maxfield Mildred Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Reverdy Road, Baltimore, Maryland 21212 Richard Maxfield Jr./ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mem Pk Ceme. 08/16/2011Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones /F/H, P.A. 21. Signature of Funeral Service L 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Onset and Death ardinascular Pnysician/ one hour Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): CANCER Cause (Disease or linjury that initiated events resulting in death) Last LUNG and tran Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year ed by the a 9 Unknown P.0. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an the Hospital or Attending Physician: The law has autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**io မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Descripting Physician to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0058860 AUG 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calvert Street Suite 555 Balto. MD 21218 DHILLUN MI) 3333 N 31. Date filed (Month, Day, Year) AUG 12 Registrar's Signature State Registrar

Mary Margaret M		1- For State	tate of Maryla		epartm <i>Certific</i>				Menta	al Hygiene	Reg. N	. 20		25	78
Physici		Registrar 1. Decedent's Name (First, Midd	lle,Last)							2. Date of I		·		3. Time of De	ath
Medical Exami	ner	Mary Margaret Mundie July 29, 2011									1627 hrs	3			
		4a. Facility Name (if not instituti 7950 Mayfair Circle	on, give street and ni	umber)				b. City, Town, or Location of Death Ellicott City Howard					Death		
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birthday)			thday)	If Under		If Under 2	24Hrs. 8. Date of	Birth(M	M/DD/YYYY)		hplace (State	or
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21215-0036 Juid be filed within 72 hours after death with the Maryland Mental Hygjene. marked ather than "natural", ur items 23a nr 28a-f sho ie event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle John William (18		Name (First, Midd guerite					
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Baltimc permit. Page Department of Important: injury or ntl		21. Signature of Funeral Service	Licensee				ame and A			Gary L. Wash. Bl					
Physician		23a. Part I. Enter the disease, o	r complications that of	aused the	death, Do n	ot enter th	e mode of	dying, su	uch as card	diac or respiratory	arrest, s	shock, or hea	rt rt	Approximate	e Interval
√ /Medical Examiner		failure. List only one cause Immediate Cause (Final disease	I be a section of a second	ve Ather	oscleroti	c Cardi	ovascula	r Dise	ase					Between Or Deal	
- Adminion		or condition resulting in death)	Due to (or as a	a conseque	nce of):										
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Division of Vital Records, P.O. Box 6876. tal or Attending Physician: The law requires that the death certificate its after death. al Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the let	Completed by									24a. W				topsy findings	
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The state of the cause of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner one) 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signature															
	2	29b. Signature and title of certification	er v	,				D.C.M				d. Date signe Ily 31, 201		nth, Day, Year)	
		30. Name and address of person			(Item 23a)							., ., .,			
10			ant Medical Exa			altimor	e Street,	Baltin	nore, Mi	D 21223					
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

n/	State Registrar	State of Ma	Ce	ertificate of L	Death	Re	g. No. 2011	25783		
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er	4a. Facility Name (if not institution, giv Gilchrist Cente		ice Care	4b. City, Town, or	Towson		4c. County of Death Baltimore			
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Ī	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Inc Black, White, etc.	dian,		
db	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N	0	1 ☐ Yes 2X No	Specify:		Specify: Whi	te		
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To Be	17. Father's Name (First, Middle, Last))				e (First, Middle, M				
	Thomas Head					ne Joycel				
	19a. Informant's Name/Relationship (James Gower, Si	Type, Print) c. /Husband		iling Address (Street 09 Tee Jay			City or Town, State, Zip Code) 21222			
	20a. Method of Disposition	- /	20b. Place of Disp				20c. Location - City or Town, S	State		
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		cemetery, cri	ematory or other place	ce)	Aug 13, 2011	Beltsville, M			
	21. Signature of Funeral Service Licer		' 	eake Crema 22. Name and Addre	ss of Facility	2011				
	Kenocra Hac	hemon	401585	Crematic	n and Fune	eral Alter	rnatives Towson Maryland	21286		
dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of): consequence of):	STRUC	TIVE PU	LIMAN	IKY DISOUS	LCARS		
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	Ectopic pregnan	су		23d. Date of delivery Month Day Year			
) SIC		bacco use contribute to the cause of death?								
	Part II. Other significant conditions			c andenying cause gi				ase or death:		
	Part II. Other significant conditions Dementi	A				1 □-1€	s 2 No 3 Probably	_		
		A				24a. Was ar	24b. Were autopsy fi	4 Unknown		
		A				24a. Was ar autops perform	24b. Were autopsy fi prior to complet death?	4 Unknown		
Completed by	Devine wT/	A			lace of Death (Chec	24a. Was ar autops perform 1 🗆 Yes 2	24b. Were autopsy fi prior to complet death?	4 Unknown Indings available tion of cause of		
	Device w (// 25. Was case referred to medical examiner? 1 □ Yes 2 ⊡ No	Hospital:	nt 2 □ ER/Outpat	26. P	lace of Death (Chec	24a. Was ar autops perform 1 Yes 2 k only one)	24b. Were autopsy fi prior to complet death? 2 No 1 Yes 2	4 Unknown Indings available Ition of cause of		
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			For State	State of N	Marylan					and Me		-	201	I	25784
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	Physicia Medic		Michael	Dougher	ty	Mo	cKee				Month August	D		ear 11	3. Time of Death 3:50 P M
	Examir		4a. Facility Name (if not institution, g	ive street and number,)		4b. City, 1	Town, or l	Location o	of Death		40	c. County of	Death	
and the same			Holy Cross Hosp						Spri				Mon		
	Funeral Director		5. Social Security Number 6 212-52-0816	. Sex 1 ፟፟፟ M 2 ☐ F	Age (In yrs. la 56	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	Min	8. Date of Birl (Month, Da Sept • 2	th y, Year) 2 1	954 W	Birthp. Coun:	place (State or Foreign try) ngton D.C.
	A		Usual Residence of Decedent										<u> </u>		
	tryland a-f sho ied at	ctor	10a. State 10b. County MOnts	gomery	10c. City	y, Town or Lo		hesc	la					1	0d. Inside City Limits 1 ☐ Yes 2 💆 No
	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip			_		10g. C	itizen of Wh	at Cour	
	with s 23a ust b	era	5812 Melvern Dr					208	317			U	nited	Sta	ates
	death item:		11. Marital Status	12. Was Deceden Armed Forces		3. 13. V	Vas Decede f Yes, speci	ent of His	panic Orig	gin? (Speci	fy Yes or No-		14. Race -		
36	after or II", or xamir	d by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2	□ No		Yes 2				,,		Specify:	White, (White
9	nours natura ical E	Completed	15. Decedent		19/4-/	16a. Deced	ient's Usual	Occupat	tion			16h	Kind of Busi	ness Inc	dustry
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Maryland 21215-0036	ntal H ed ot	To B	17. Father's Name (First, Middle, Las Richard Gris	,	. 17						First, Middle,			M 1	
Ž	ould b		19a, Informant's Name/Relationship		cKee	10h Mailie	a Addrasa	(Stroot or		rine	Mai Route Numbe	jor			gannon
	e 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other than " or other traumatic event, the Med		Anette B. McKee				-				esda, N		2081		Jode)
J.	1 and of Hei		20a. Method of Disposition			lace of Dispo emetery, cren			,	Da	ite	20c. L	ocation - C	ty or To	own, State
<u>ii</u>	Page ment ant: It ury or		1 ☐ Burial 2 💢 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from Sta ecify)	i.c	esapeal	-			8/11/	/2011		Belts	svil	le, MD
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ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2xx No	Hospital:				Other		th (Check o					
of V	Phy this	은 ::	1 ☐ Yes 2★★No 27. Manner of Death	28a. Date of in	niury	ER/Outpatier 28b. Time of		Bc. Injury	4.∐ Nu at	1	ie 5 🗌 Resid 3d. Describe h	_		Specify)
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	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Exa	hysician: To the best aminer: On the basis of lurse Practioner: To the	f examination	and/or invest	tigation, in n	ny opinion	n, death oc	curred at the	ne time, date a	and plac	e, and due to	the car	use(s) and manner stated
	To the within 2 To the comple	2	29b. Signature and title of certifier	arse Fractioner. To the	ie best of m	Knowledge, t		License		and place,	and due to th		ate signed (/		
								D64	4983			Α	UGUST	10,	2011
	20+1		30. Name and address of person wh		,										
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	Sta	te	31. Date filed (Month 16, 12 2	011 3 Regis	trar's Signat	ture									

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			State of Maryland				•	•	oie.			
		1 - For State Registrar	otato ot maryiani		rtificate of L			eg. N O N	1 25705			
Physicia Medic		1. Decedent's Name (First, Middle, Las	Morgan				2. Date of Deat Month	201	/ear 8.45 A M			
Examin		4a. Facility Name (if not institution, give	street and number)	for a b. I	4b. City, Town, or	Location of Death		4c. County of				
Funeral Director		 Social Security Number Sé 	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Jun 17,		9. Birthplace (State or Foreign Country) Pennsylvania			
show	ō	Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits			
e Maryk r 28a-f notified	Funeral Director	Maryland Howard			Woodsto	ock			1 ☐ Yes 2 🛣 No			
s 23a o	erall	11160 Chambers Co	urt Unit L		10f. Zip Code 211	63		0g. Citizen of Wh United S				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	-	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto			American Indian, White, etc.			
2 hours "nature dical E	Completed	15. Decedent's Ec		16a. Deced	dent's Usual Occup	ation	ing	16b. Kind of Busi	White			
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nould to the Me was mark and the mark and th		William Silas C 19a. Informant's Name/Relationship (Ty,	ripps pe, Print)	ng Address (Street a			affer	re Zin Codel				
ind 2 sh Health a Im 27 is her trau		Roger L. Arnold,		1116	0 Chambe			-				
age 1 a ent of H nt: If ite ry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State ce	emetery, cren	sition (Name of natory or other plac ney Crema:	e)		20c. Location - Ci				
permit. F Departm mporta Iny inju		21. Sign wre of Funeral Service License	ee f						ne, Maryland Box 784 ille, MD 20129			
42 = 4 O		23a. Part 1. Enter the disease, or comp	olications that caused the death						Approximate			
hysician/ Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		Asso	ociofel .	Revisor	10		Interval Between Onset and Death			
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nysician; the law requires that the death certificate in is certificate has been signed by the attending physial director, page 2 should be detached for use as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 [Ectopic pregnanc Other (specify)	у		23d. Date of Month	· ·			
v requires that the desibeen signed by the a should be detached	by Ph	Part II. Other significant conditions co		_		en in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?			
requires been sig hould b	eted	Atrial Fibrillation	re Polmoner	12 /	near	Failor	-		Probably 4 Unknown			
cate has t page 2 s	Completed by		re Polmono	, d	liseuse		_ perform	a. Was an autopsy audipsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
sician; certific irector,	Be	25. Was case referred to medical examiner?	Hospital:	pital: Other: Other:								
to the ropspiral or Attending Priysician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 E 28a. Date of injury (Month, Day, Year)	R/Outpatien 28b. Time of injury	28c. Injury work	4 □ Nursing Ho	ome 5 Reside 28d. Describe hov		Specify)			
spiral or Arre fours after de neral Directo filled in by th	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office	28f. Location (Str. City or Town,		or Rural Route Number,				
ne nospi in 24 hour he Funera pleted fills	Medical	(Check 2 ☐ Medical Examin	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or invest	igation, in my opinio	 n. death occurred a 	the time, date and	place, and due to	the cause(s) and manner stated			
withi To th		29b. Signature and title of pertiner	1 20	20-	29c. License		1	d. Date signed (A				
John		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type, P	rint) \mathcal{V} \mathcal{T} (0120		tug 1	1, 2011			
Stat	е	31. Date fled (Month, Day Year)	32. Registrar's Signatu	Char	- for Dr.	Colum	Sic M	10	21044			
Registra		AUG 1 2 2011	we B. fa	Ker								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No U Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death MCCU Month Physician/ 950 AM 01/20 201 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 940 Decesaris Drive Lothian Birthplace (State or Foreign Country)
 Maryland If Under 24 Hrs 8. Date of Birth Social Security Number . Age (In yrs. last birthday) Funeral 1 XM 2 □ F Months Days Hours Min. (Month, Day, Year) 06-29-1961 Director 50 213-82-2237 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No MD Anne Arundel Lothian 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20711 940 Decesaris Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. and Mental Hygiene. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced White traun atic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel County Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marilynne E. Dugan Martin E. McCullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 940 Decesaris Drive Lothian, Maryland 20711 Suzanne A. McCullen / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 08-09-2011 Odenton, Maryland Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Si vati re o Funeral 3 ther the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Part 1. Interval Between Donset and Death Immediate Cause (Final Physician YEAR -415 disease or condition) Medical resulting in death) Due to (or as a consequen - of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran: Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 2 No ed by the a Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ည 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural injury work? 5 Pending 2 No Accident Investigation Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

CXIV

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8/8

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** /Medical 2011 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mency

5. Social Security Number 1 tronore Medi enter Butimore
If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2.25F Months Yrs. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Completed by Funeral Director 1 XYes 2 No Balt imore 10e. Street and Number 10g. Citizen of What Country? 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XNever Married 2 ☐ Married 1 ☐Yes 2 If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NIB Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Wendy Massey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Wendy Massy 20a. Method of Disposition mother Itimore Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bradley-Askton Funeral 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. , 2134 Willow SprincRd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) oreterm /Medical Due to (or as a consequence of): Examiner lacental Sequentially list conditions, if all y, leading to himselfate cause. Enter Underlying Cause (Disease or injury that initiated exerts Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed horioa mnio that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d, Date of delivery 3 Ectopic pregnancy Month Day Year Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 🗆 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23020 01-01-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place St Paul MD 21202

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 6, Physician/ 9:50 AM Eugene Bryant Mitchell, Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 5403 Albemarle Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **№** M 2 🗆 F Days Hours 576-52-1976 January 25, 1951 60 Massachusetts **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery 1 Yes 2 X No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5403 Albemarle Street United States 20816 "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates. Vietnam Completed event, the Medical 16b. Kind of Business Industry United States 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Naval Officer Navv permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>til</u> once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Eugene Bryant Mitchell Ella Hamilton Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Mitchell/Sister 5403 Albemarle Street, Bethesda, Maryland 20816 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 10, 2011 Monte on the place)
Crematorium, Inc. 1 Burial 2 N Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland Bethesda, Maryland 20814. Pumphrey Funeral Home/ c. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licens M01498 10 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗋 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) mo Dmc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 25789 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Day 2011 10:36AM [™] 6, Virginia Patterson Moser August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 11805 Enid Drive Potomac If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Months Hours December 17, 1930 Massachusetts Yrs. 579-48-2964 Director 80 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🗶 No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 11805 Enid Drive items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. P ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Specify: White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Marguerita Francesca Ginn James Bernard Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11805 Enid Drive, Potomac, Maryland 20854 William M. Moser, Jr/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of August 10, 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2011 21. Signature of Funeral Service Licensee Robert Address timping Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 Week Ph sician/ Bowel Obstruction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2 Weeks Abdominal Cancer with Metastatic Disease Sequentially list conditions, Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Month Day Pregnant at time of death detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 9 Clostridium Difficile Infection secondary to 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an antibiotic treatment has autopsy perform death? After this certificate 2 X No 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Suicide Investigation Could not be 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License numbe 29d. Date signed (Month, Day, Year) D32610 August 8, 2011 ress of person who completed cause of death (Item 23a) (Type, Print) Thomas 10215 Fernwood Road # 100, Bethesda, Maryland 20817 J. McNamara, M.D. State Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mateo 20 1 1 Carmen Maria 7:40 AMAugust Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 5506 Spruce Tree Avenue Bethesda Social Security Number 8. Date of Birth (Month, Day, Year) June 9, 1952 **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 I Months Min Hours Spain 218-08-2537 59 Director June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 5506 Spruce Tree Avenue 20814 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 🖫 Yes 2 🗆 No Specify: Spaniard "natural", 3 Divorced 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Evaristo Mateo Josefa Navarro and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 s of Health a item 27 Jose Serrano /Husband 5506 Spruce Tree Avenue, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ō August 12. Ξ 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) injury or permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) $\bar{2}011$ Montgomery Crematorium, Inc Bethesda, Maryland 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Signature of Funeral Service Licensee M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
Weeks Immediate Cause (Final Physician/ 2 disease or condition Liver Failure **Medical** resulting in death) Examiner Dedifferentiated Liposarcoma 6 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death
Unknown 1 Yes 2 2 9 Unknown the signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 💢 No Other: 1
Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation
6 Could not be M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

W

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

Christian F. Meyer,

31. Date filed (Month, Day, Year)

D61769

401 North Broadway Street, Baltimore, Maryland 21231

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 09 2011 9:23 A JACOB MAX Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/ASINAI HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 F Days Months Hours 04/16/1924 **Director** 219-12-5603 87 AUSTRIA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 9 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 6317 PARK HEIGHTS AVENUE, #211 21215 items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗓 No Specify "natural" Completed 3 Widowed 4 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 5+ RABBI RELIGION event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be file Department of Health and Mental tinportant: If item 27 is marked o any injury or other traumatic evenone. မ **JESCHIE** MAX CLARA GITTLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN MAX/WIFE 6317 PARK HEIGHTS AVE, #211, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 08/11/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt levins 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 2 No the Unknown 9 Ulnknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2EXNo Other: 1 🔲 Yes ည Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 2 ☐ Accident 3 ☐ Suicide 1 Yes 2 No M neral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined rite, in 24 hour. o the Funeral Di-completed fille Medical 29a. Certifier 1 Qeertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6 who completed cause of death (Item 23a) (Type, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25792 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20:57 DNay Medical 4a. Facility Name of not institution, give street and number)
Inversify of manyand medical
A2. Sputh Green Street 4b. City, Town, or Location of Death 4c. County of Death Examiner Kaltimore Street Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Days Hours Min 220-06-9192 MD Yrs. **Director** 03/19/1969 Usual Residence of Decedent 28a-f shov 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13159 River Road 21639 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2X No Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: "natural", Completed 3 Divorced 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) College (1-4 or 5+) Chief Financial Officer Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jonathan L. Norwig, Jr. Reva Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father 1 Ridgeway Drive Ridgely, MD 21660 Jonathan L. Norwig, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park: 08/08/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 21. Signature of Funeral Service Singleton Funeral & Cremation Services, PA MOU21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final reumonia Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Year Day Pregnant at time of death been signed by the should be detached Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an cate has prior to completion of cause of death? autopsy performed? this certificate 2 No 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 M No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director; After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 \subseteq Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Jason

Greene Street

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South

Baltimore,

			For State Registrar	State of Maryla	_	artment of He <i>tificate of De</i>			giene 201	1 25793
	DI		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
2400	Physicia Medic		MILDRED NAGEL					AUGUST	9, 20	Year 11:50 P M
	Examin		4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, or Lo	ocation of Death		4c. County o	
200	Funeral		1013 BARRYMORE DR 5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State or Foreign
-	Director			м 2Х□ ғ 93	Yrs.	Months Days	Hours Min.	(Month, Day 10/25/1		Country) MD
	how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation		10/25/1		10d. Inside City Limits
	faryla Ba-f s tified	Director	MD HARFORD		BEL AI	?				1 ☐ Yes 2 🛣 No
	the N		10e. Street and Number		DDD MIL	10f. Zip Code			10g. Citizen of Wh	nat Country?
	h with ns 23a nust l	Funeral	1013 BARRYMORE DR			21014			USA	
	r deat or iten niner i	by Fu	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No 	U.S. 13. V	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at	q pa	Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify:	HITE
2-0	2 hour	plet	15. Decedent's Educ (Specify only highest grade		(Give I	lent's Usual Occupati kind of work done dur		ing	16b. Kind of Bus	iness/Industry
121	ene. • than • the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOMEN	ONOT use retired)			OWN HOM	fF
od 2	filed withi al Hygien d other th	Be	17. Father's Name (First, Middle, Last)		HOPIE		8. Mother's Nam	e (First, Middle,	Maiden Surname)	
ylar	should be file and Mental 7 is marked or raumatic eve	2	CHARLES DAVIS				MARGARE'	r KEATIN	1G	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type KATHY LEWIS-DAUGHTE:	*		ng Address (Street and BARRYMOR			r, City or Town, Sta MD 2101	
Baltimore,	ge 1 an nt of He : If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation 3 ☐ Re	moval from State		sition (Name of natory or other place) CREMATORY		Date		City or Town, State
Itin	permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation 5 Other (Specify) 21. Signature Funeral Service Circles	A			GLEN BUF FUNERAL F	OME OF BELAIR		
Ba	Depar Impo any ir once.		Polebic &	1 < MOIZ	HAIL RD		IR, MD 21			
Ī			23a. Part 1. Inter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the decause on each line.	eath. Do not ente	er the mode of dying,		or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition resulting in death)	Due to (or as a conse	equence of):		CVA			
	LAGITITICI	Jer	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a conse	equence of):					
	cate be executed physician and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease of Trijury that initiated events c.							- 83
_	oe exer	al E	resulting in death) Last	Due to (or as a conse	equence of):					
392	icate l	l edical	d.							
Box 68760	ending r use a	an/N	200. Was decedent pregnant	c. If yes, outcome of preg 1 Live Birth 2 F	gnancy fetal death 3	Ectopic pregnancy				of delivery
. Bo	ss that the death certific igned by the attending is be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Mont	th Day Year
P.O.	that the	by Pł	Part II. Other significant conditions conti	ibuting to death but not	resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ds,	requires been sig should b							1 🗆 '	Yes 2 □ No 3	3 ☐ Probably 4 ☐ Unknown
Secol	he law re te has be age 2 sh	Completed						24a. Was autop perfo 1 Yes	rmed? de	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
alE	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place	e of Death (Chec		2/2(110)	E 163 2 E 110
Ξ	Physic this ce al dire	은	1 🗆 Yes 2 🏲 No	spital:				•	lence 6 Other	· / · / · · · · · · · · · · · · · · · ·
ou o	ending F sath. rr: After i he funer	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work? M 1 🗀 Ye	t es 2 □ No	28d. Describe h	ow injury occurred	1
Division of Vital Records,	al or Atto s after de l Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office	10	28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical			tion and/or invest	tigation, in my opinion,	death occurred a	t the time, date a	nd place, and due t	to the cause(s) and manner stated.
	To the composite of the	-	29b. Signature and title of certifier			29c. License n			29d. Date signed	
	•		7007	MD			62190			0/2011
			30. Name and address of person who com	pleted cause of death (It	em 23a) (Type, F	INE HORM	AN HWY	SVITEA	CHESAI	PEAKECHY, ND
	Stat Registra	te ar	30. Name and address of person who come SHA HNAWAZ KH7 31. Date filed (Month, Day, Year) AUG 1 2 2011	-/	21915					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Soon Ye Park August 2011 10 10:00P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2510 W. Patapsco Ave. Baltimore 5. Social Security Number Date of Discourse (Month, Day, Year 20 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Korea Days Hours **Director** 213-96-7100 94 August Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2510 W. Patapsco Ave. #2C 21230 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceuent 2 Armed Forces? 1 Yes 2 Tyle 14. Race - American Indian, þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 VNo 3 XXWidowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20809 Gaelic Ct., Germantown, Maryland 20874 Catherine Kim / Granddaughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Trurial 2 Cremation 3 Removal from State Meadowridge Memorial 8/12/2011 Elkridge, Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-trans

Physician, Medical Examiner

Baltimore, Maryland 21215-0036

29b. Signature

Division of Vital Records, P.O. Box 68760

	4 🗆 Donation 5 🗆 Other (Specify)						
	21. Signatur of Funeral Service License	X)		d Address of Facility $Gata$			ral HOme,Inc. and,21075
	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition	ications that caused the death e cause on earnine.	. Do not enter the mod		or respiratory arrest,		Approximate Interval Between Onset and Death
_	resulting in death) Sequentially list conditions.	b.	once on.				
Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	Directo (or se si noi sequi					
	resulting in death) Last	Due to (or as a conseque	ence of):				
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic			23d. Date of de Month	elivery Day Year
ted by PI	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying o	cause given in Part I.			o the cause of death?
Comple					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s
Be	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
၉	1 L Yes 2 KNO		ER/Outpatient 3 🗆 D0	Other: 4 Nursing H	Home 5 Residence	6 Other_(Spec	cify)
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	28b. Time of 2 injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory	, office	28f. Location (Street a City or Town, Stat		ural Route Number,
Medical	(Check 2 L. Medical Examine	cian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or investigation, in a	ny opinion, death occurred	at the time, date and place	e, and due to the	cause(s) and manner stated.

State Registrar of person who completed cause of death (Item 23a) (Type, Print W. WHITHM) 2835 51

		For State Registrar	State o	f Marylan		irtment of <i>tificate of</i>		d Mental Hy	/giene Reg. N2 0		25795
Physicia		1. Decedent's Name (First, Middle,		earce				2. Date of D Month Augus	eath Day	Year 2011	3. Time of Death 8:20A M
Medic Examin		4a. Facility Name (if not institution, Baltimore Washi		*	enter	G1	or Location of De en Burni	eath .e	4c. Count	y of Deat	Arundel
Funeral Director		214-20-9108	6. Sex 1 ⅓ M 2 ☐ F	7. Age (In yrs. la	ast <i>birthday)</i> Yrs.	If Under 1 Yea Months Day		Hrs. 8. Date of B Month, D March	rth a <i>y</i> ,1 ^{Ye,ar)} 1925	9. Birt Cot Ma	hplace (State or Foreign Intry) ryland
faryland 3a-f show iified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel		y, Town or Loc adena	ation					10d. Inside City Limits 1 ☐ Yes 2 🌂 No
with the N 23a or 29 ist be no	Funeral Director	10e. Street and Number 198 Southwood R	oad			10f. Zip Code	21122		10g. Citizen of USA	What Co	untry?
2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 🗆 No	l If	/as Decedent of Yes, specify Cu ☐ Yes 2 🛣	ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ck, White	rican Indian, e, etc. white
within 72 hours after giene. er than "natural", o , the Medical Exam	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 6 t.h		4 or 5+)	(Give k	NOT use retire	e during most of v d)	working	16b. Kind of E		tanker
2 should be filed w th and Mental Hygi 27 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Launknown	st) Peai	cce	0140			Name (First, Middle			
		19a. Informant's Name/Relationshi Sandra Phillips	p (Type, Print) daught	er				Rural Route Numb ad Pasade			Code)
oermit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State C	emetery, crem	sition (Name of latory or other p natory I		Date LO/11	20c. Location Baltimo	-	
permit. Page Department of Important: If any injury or	1	21. Signature of Funeral Service Li	Isee		- 1:	Name and Add		Stalling Pasaden			ome P.A.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or impury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. Due to (d) d. 23c. If yes, out 1	Birth 2 🗌 Feta nant at time of c	uence of):	Ectopic pregna Other (specify)				ate of del	ivery Day Year
ires that the d signed by the id be detached	by	9 Unknown Part II. Other significant condition	9 Unkn		ulting in the u	nderlying cause	given in Part I.		tobacco use con		the cause of death?
The law requ ate has been page 2 shoul	Completed	Palle	now	2					opsy formed?	prior to death?	topsy findings available completion of cause of
ending Physician: eath. or: After this certifi the funeral director,	Certificate: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of eath Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could n	28a. Date of (Montation	Inpatient 2 of injury h, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 DOA O		g Home 5 ☐ Res	nidence 6 Otl		ify)
pital or Att burs after d eral Direct filled in by t		4 Homicide determin	ned 28e. Place buildir	ng, etc. (Specify	·)	et, factory, office		City or To	wn, State)		ral Route Number,
To the Hos within 24 hr To the Funcompleted:	Medical	(Check Z Medical Ex	Physician: To the beaminer: On the bas Nurse Practioner: 1	is of examination	and/or invest	gation, in my opi	nion, death occurr	ed at the time, date	and place, and d	ue to the	cause(s) and manner stated
2		30. Virma and pure of person w	lo amplete caus	e of Dean (Item	(Тура Р	100 0	None	Ann I	20/	0.4	V Man
Stat Registra		31. Date if the VAVODY, 2774 (year)	Server 32. Re	egistrar's Signat	ture	11 8	IT VON	AMA	100	(W)	vand life

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death (e-1 6 If Under 24 Hrs. Hours Min. Security Number If Under 1 Year
Months Days 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland 1 🔀 M 2 🗆 F Months (Month, Day, Year) OV. 15, 1919 215-12-2626 Director 91 Nov. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 1 🗌 Yes 2 🔀 No MD Prince George's Glenn Dale 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12007 Green Court 20769 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 Yes 2 Completed by 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give marked other than "natural", Specify White 3 Widowed 4 Divorced Year or Dates. 1941-45 other traumatic event, the Medical 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wage & Salary Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Pulaski Marie Banach 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 shou ment of Health and tant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12007 Green Ct., Ruth H. Pulaski / Spouse Glenn Dale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 🖔 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Lakemont Mem. Gards. 8/13/2011 Davidsonville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral 6512 NW Crain Hwy., Bowie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) des Medical Examiner Due to (or as a consequence of): ectal CU Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month 1 Yes 2 g 2 No the g Unknown certificate has been signed by ' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ fib-1119to 2 No 3 Probably W Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မှ Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide م 24 hou. the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Mont)

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amend #10c of Per FH C918 8/16/2011 IH and Mental Hygiene amend #1 Per PHY G918 8/23/2011 JH Certificate of Death for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 7,2011 Nickolas M. Pavlos 6:55A. Nicholas M. Pavlos Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗙 M 2 □ F Days Hours 9-28-1920 Mary I and Yrs. **Director** 90 215-14-9137 Usual Residence of Deceden 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nottingham Md. Balto. Perry Hall 1 Yes 2x No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Apt 1G 21236 Funeral 3901 Hannon Court Apt. 16 21128 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Railroad Passenger Conductor traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) P permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Michael Pavlos Clara Thanu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Appomattix Pl. Franklin, Tn 37064 Son Michael Pavlos 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. 8-11-2011 Woodlawn, Md. 21. Signature of Funera Service Licenses 22. Name and Address of Facility ^{2. Name and Address of Facility} Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease of complications that caused t shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? page 2 should be detached for Dav Pregnant at time of death the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔐 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? safter death.

| Director: After this certificate | 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) + OSpice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury filled in by the 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier eted 1 (Check Cert ving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sianature nd title I 29d. Date signed (Month. Day. Year) $N \cdot D$. 18211000 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, Balthuere, MD 21204 6701 N. Chee State AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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3		State Registrar	est Middle	(a at)			<i>C</i>	ertificat	e of L	Jeatn		2. Date of Dea	Reg. No.	UL		2 3 . Time of	Death
Physicia		1. Decedent's Name (Fi										Month July	Day 29	20.	ar	3:23	РМ
/Medic Examin		Delores M 4a. Facility Name (If not			and nun	nber)		4b. City,	Town, or	Location	of Death			ounty of D	eath		
		12518 Rid							dge1					arol:			
Funeral		5. Social Security Numb		6. Sex 1 ☐ M 2	ΔF	7. Age (In) 80	yrs. last birthda Yrs.	y) If Unde Months		If Under Hours	Min.	8. Date of Bird (Month, Da March	h y, Year) 19:		Country Vir	ce (State o y) ginia	r Foreign
Director		Usual Residence of Dec								ļ							
arylan show	_	10a. State 10i	Car	oline		10c.	City, Town or Ridge 1								100	d, Inside Cit 1 ☐ Yes	
the Mi	recto	10e. Street and Number		OTTIC				10f. Zij	n Code				10a. Citize	en of What	Countr		
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ems 2	Funeral Director	11. Marital Status	-02	12. Wa	as Dece med Fo	dent Ever i	n U.S. 1	B. Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	- 14	1. Race - A Black, W			
s afte	by Fi	1 X Never Married 3 Widowed 4 □		ed 1 [∃Yes ∕es, Giv ear or Da	2 [X] No ∕e		1 □Yes		Specify					whit		
2 hour atural	ted t	15.	Decedent'	s Education		ates.	16a. De	cedent's Usu	al Occup	ation			16b. Kind	d of Busine	ess/Indu	ustry un	
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Hygier Hygier Iher th		1.7. Father's Name (Firs	t Middle I	act)	()		secret	ary	18 Moth	er's Name	e (First, Middle,	Maiden S	urname)			
d be f ental I ked oi ic eve	To Be	Charles			od							e Jaspe					
and M s mar		19a. Informant's Name	Relationsh	ip <i>(Type. Pr</i>	int)			0				al Route Numb					
and 2 lealth m 27 i	ar a	Mark Per		son						Hill		Keedysv					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Macical Examinar must be inclifted at once.		20a. Method of Disposit 1 ☐ Burial 2 ☐ Ci 4 🖾 Donation 5 ☐	emation		al from S		b. Place of Dis cemetery, c	position (Na rematory or (me of other plac	e)	ι	Date	20c. Loc	ation - City	orlow	n, State	
permit. Departr Importa any inji		21. Signature of Funera	Service L	icense	e	irec	tor					st; Ba	_			1201	
		23a. Part Enter the d shock, he int fa Immediate Caus (Fina	lure. List o	omp ication only one cau	se on e	ach line.			de of dyin	ig, such a	s cardiac	or respiratory a	rrest,			Approximate Interval Bet Onset and I	ween Death
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death certificate b attending physic	Physician/Med	23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☑ 10	iths?	1	Live t	come of pre pirth 2 1 I nant at time	Fetal death	3 ☐ Ectopic 5 ☐ Other (s		у			2	3d. Date of Month		-	Year
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To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. Coppletely filled brector: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	þ	Part II. Other significar	t conditio	ns contributi	ng to de	eath but not	resulting in the	underlying	cause giv	en in Part	1.		obacco us Yes 2□		te to the	e cause of cably 4	leath? Unknown
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ath. rr: Afte	atjo	2 Accident	☐ Pending investig	ation	(Mon	th, Day, Yea	nr) Injur	M	Worl	k? Yes 2□	□No						
or Atte	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could n determi		e. Place buildii	of Injury - Ang, etc. (St	At home, farm, pecify)	street, factor	ry, office			28f. Location (City or To	Street and wn, State)	Number	or Rural	Route Num	nber,
Hospital 4 hours 7 tuneral tely filled		(Check only 2		xaminer: 0	n the b	asis of exa						, and due to the red at the time,					3)
Fo the within 2 Fo the comple	Medical	one) 29b. Signature and title	of certifier	a	nd mani	ner stated.		29	c. Licens	e number				signed (A		Jay, Year)	
		▶ Lath	m U	aidy	jano	atha	n M	DI	003	57	749	7	Fluga	15T	3	2011	
		30. Name and address LAKSHMI	VAI	AYC	NA	THAC	1 210	1 S. W	ASH	INGT	0N 9	$s\tau, \epsilon$	ASTO	ON,	MD	21	601
Sta Registr		31. Date filed (Month, E	lG 12	2011	32.	egistrar's S	ignatu	parke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ TOY Piltman 11:28 A M August 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Months Days Hours FEBONTA Day, Year 1931 ន្តព Director 213.28.4192 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2XX No **GLEN BURNIE** MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral USA 21060 8 IVY LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) filed within MEDICAL OFFICE ASSISTANT 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ FRANCES BROY permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. WILLIAM HARVEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 IVY LANE GLEN BURNIE, MD 21060 GENE PITTMAN SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XXBurial 2 Cremation 3 Removal from State GLEN BURNIE, MD **GLEN HAVEN CEMETERY** AUG 9, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa Funeral Service FINK FUNERAL HOME, P.A. GREGORY FINK ĸ. M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ily one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Lit Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyopathy End-stage Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Day Pregnant at time of death signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) + hospice ျ 2 4 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

2835 Smin 31. Date filed (Month, Day, Year) . Registrar's Signature

nsky apamem 10

N.S. Rajapa KSR, MID.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00057465

5-203

8/5/11

Baltimore MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{Year} Francis R. Pazderka August 10, 4:40 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Severna Park Anne Arundel Severna Park 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 14, 1951 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min 1 X M 2 🗆 F Months Hours 212-60-3230 **Director** 60 Yrs Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Md. Pasadena 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7800 Harbor Drive 21122 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 - Widowed 4 X Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Optical Glasses 12 years Optometrist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Francis J. Pazderka Florence M. Fines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence M. Hatfield Mother 969 Tierra Lago Way, Naples, FL 34119 20a. Method of Disposition August 13, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Dundalk, Maryland 2011 4 Donation 5/2 Other (Specify) Sacred Heart Of Jesus 21. Signature of Funeral S ^{2. Name and Address of Facility}
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, 23a. Part 1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day 1 Yes 2 9 Unknown signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Alatural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, after o completed filled in by

> State Registrar

Medical

29a. Certifier (Check

only one 29b. Signatur.

ne and address

31. Date filed (Month, Day, Year)

AUG

To the within 2

istrar's Signature

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the Lest of my knowledge, coefficient of my knowledge, and manner stated.

completed cause of death (Item 23a) (Type, Print)

rune 2/ 08 Pi Dmih Drive Chily MD 21619

37 03 6

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

_	For State Registrar 1. Decedent's Name (First, Middle,		arylan	•	artment of F tificate of E			Reg. Na	011	2580
cian/ dical	Sally C.						August	Dav	201	
iner	4a. Facility Name (if not institution, Future Care		đ			Location of Death			ounty of Dea	imore
al or	578-38-8040	6. Sex 1 ☐ M XIXF 7. Ag	e (In yrs. Ia 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Aug • I 8	Year) 9 2	9. Bi	irthplace (State or Foreigr ountry) aryland
ctor	Usual Residence of Decedent 10a. State 10b. County	imore	1	, Town or Lo				·		10d. Inside City Limits 1 ☐ Yes ※XXN
Funeral Director	MD Balt 10e. Street and Number 11935 Park			rings	Mills 10f. Zip Code	1117		-	n of What C	Country?
þ	11. Marital Status 1 Never Married 2 Marri 3 Widowed XXDivorced	12. Was Decedent I Armed Forces?	Ever in U.S	1	Was Decedent of Hi f Yes, specify Cuba ☐ Yes XX No	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Am Black, Whi	erican Indian,
Completed	15, Deceden (Specify only highes Elementary/Seconday (0-12)	t's Education	5+)	(Give i life. Di	dent's Usual Occup kind of work done o O NOT use retired)	luring most of work			l of Business	
Be C	12 17. Father's Name (First, Middle, La	no th		Medi	ical Bil	1ing Cle			11th	Care
To [Archangelo T						line Ca			
	19a. Informant's Name/Relationshi Carol Lundstr	ip (Type, Print)	ter			and Number or Run	al Route Number,	City or To	wn, State, Z	(ip Code) 21117 111s, MD
	20a. Method of Disposition 1 ☐ Burial XX Cremation 4 ☐ Donation 5 ☐ Other (Se	3 Removal from State	20b. PI C∈	lace of Dispo emetery, cren	sition (Name of natory or other place aiths ry & Cha	e)	Date	20c. Loca	ition - City o	r Town, State
once.	21. Signature of Fune al Service Li			22	. Name and Addres	ss of Facility Eck	hardt F	uner	al Ch	napel P.A. 11s,MD211
n/	23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)		е.	Sei	er the mode of dying		or respiratory arre	est,		Approximate Interval Between Onset and Death
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as					-			
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Fetal	Ideath 3	Ectopic pregnand	у		23	d. Date of d	elivery Day Year
by	Part II. Other significant condition	ns contributing to death b	out not resu	ulting in the u	nderlying cause giv	ren in Part I.				to the cause of death? Probably 4 \square Unknow
Completed							24a. Was a autops perfor 1 🗆 Yes	sy med?	prior to death?	utopsy findings available completion of cause of es 2 \square No
Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Chec	k only one)			-
cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	1 ☐ Inpati 28a. Date of inju (Month, Da	iry	ER/Outpatier 28b. Time of injury	28c. Injury work	4 Nursing Ho	ome 5 Reside 28d. Describe ho			ecify)
Certificate:	3 Suicide 6 Could n 4 Homicide determin	ot be			eet, factory, office		28f. Location (St City or Town		lumber or R	ural Route Number,
Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination	and/or invest	igation, in my opinio death occurred at the	n, death occurred a e time, date and place	t the time, date an ce, and due to the	d place, ar cause(s) a	nd due to the nd manner a	e cause(s) and manner sta is stated.
	29b. Signature and title of certifier				29c. License	number 37 <i>5</i> 73	2			th, Day, Year)
7						0.0	- 1	140	ופטרו	117 0011

Box 68760 P.O. Records, Division of Vital Hospital or Attending within 24 hours at er death.

To the Funeral Director Af
completed filled it by the fu

Baltimore, Maryland 21215-0036

28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

A. Chilakamass 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar D69568

6121 Montrose Rd, Rockville, MD

08/09/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 50 A M Physician/ Year Ridge en 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ASSISTED Kris Anne Arunde UVINO Gambrills 6. Sex 7. Age (In yrs. last birinday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 214-10-1866 **Funeral** Months Days April 26, 1916 1 □ M 2 🔯 Hours Maryland **Director** 05 5668 95 Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Severn Maryland Anne Arundel 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be items 23a Funeral 21144-2811 United States 8351 New Cut Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: White 3 🕅 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) -12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clara Wantz Martin Ritchie permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8351 New Cut Road, Severn, Maryland 21144-2811 Gary F. Ridgely/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date West Arundel other place) 1 Durial 2 XI Cremation 3 Removal from State August 11 2011 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland Crematory 21. Signature of Funeral Service Li 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will Export M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ HTN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner M 105 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months 1 Yes 2 No ò Month Day Year signed by the ar 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>δ</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 HNO this certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Yes CNO မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Latural atural
Accident
Suicid 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Hospital Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0044184 nd address of person who completed cause of death (Item 23a) (Type, Print) 30 Name 179 Jumpes Hole Pd Severne Park MD 21146 Marsha Y Blakeslee

State

Registrar

31. Date filed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25804 Reg. No. Certificate of Death Name (First, Middle 2. Date of Death Physician/ obinson 0150 M 2011 Medical not institution, give street and number Examiner 4c. County of Death gnes PI ta mmore 7. Age (In yrs. last birthday) Yrs. If Under 24 Hrs. If Under 1 Year 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 DF Country) Director 28a-f shov 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at **Funeral Director** MD Baltimore 1 ¥Yes 2 □ No 5 10g. Citizen of What Country? items 23a ulver 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) nday (0-12) omestic Be other traumatic event, 18. Mether's Name (First, Middle, Maiden Surname, ames Department of Health ar Important: If Item 27 is any injury or other trau lanns Daughter 600 Kenora Wood 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) re of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death
12 hours Immediate Cause (Final Isclemia Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the attending physician and ned for use as the burial-transi that initiated events resulting in death) Last Hypertension Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physiclan: The law requires th within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be or 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No Yes 2 No 1 🗌 Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident work? 1 🔲 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 900 Caten Ave, Baltimore, 21229, MD 4GEGNEHU GEB 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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10,

AUGUST

JOYCE RECKENBERGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZOII Physician/ Month 15 PM Lla Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Da more If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Min. 02471371928 GREECE 1 M 2 X 216-54-6639 83 Yrs. Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** X□ Yes 2 □ No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 SAVAGE STREET 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: SpecifWHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOUSEWIFE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ KONSTANTINA UNKNOWN IOANNIS KOLOKITHAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 SAVAGE STREET BALTIMORE, MD 21224 JOHN STAMATOPOULOS-HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OAKLAWN CEMETERY 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/11/2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER FUNERAL HOME Signature of Funeral Service Licenses 6224 EASTERN AVENUE BALTIMORE, MD 21224 23a. Part | Enter the disease or o shock, or heart failur . I st on or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onsat and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a nonsecuence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, oronaru 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Dalumore, IMaryland ZIZI3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	3	21. Signature of Funeral Service Li	Cartwri	ght Fu	enral	Home								
		232 E. Fairfax Lane Win										ster,	VA 22	2601
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Me	only one) 3 Certifying	Nurse Practioner:	To the best of m	y knowledge, d	eath occurre	ed at the t	time, date	and place	e, and due to the	cause(s) and	manner as st	ated.	
No No No No No No No No No No No No No N		29b. Signature and title of certifier	104	1		29c. l	License n	number	(1)	2	29d. Date sig	ed (Month,	Day, Year)	
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Regist	rar	AUG 1 2 2011	enery)	. Igun	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sage **Physician** Scott 11:45 PM Samir 04 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Mercu Medical Center 5. Social Security Number 6. Sex 1 **X** M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Min Director NA 24 2011 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Kres 2 □ No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö items 23a 1617 USA 21213 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

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To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 1588938013 04-24-2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 301 Saint Paul Place, Battimore MD

Merkel

aura

MD

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Sco **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death **Examiner** BALTIMORE CIT MERCY MEDICAL CEN EK BALTIMORE CIT If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Director 07-28-2011 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f shoi other traumatic event, the Modical Exeminer must be notified at 1 Nes 2 No Be Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Kentucky Ave

12. Was Decedent Ever in U.S.
Armed Forces?
1 | 1 | Yes | 2 | No 3301 2121 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes. Give 3 Widowed 4 Divorced Black Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည larran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1timore Inu Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Egneral Service Licenses Name and Address of Facility 12134 Willow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreit, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Oday disease or condition resulting in death) /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a con lequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ filled in by the funeral director, page 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed 1 XYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Mariner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar DHMH 17 Rev 1/2001 BAZIMORE, MO ZIZOZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:17P Kathleen Santamaria Physician/ Mary Month August 4, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 555 South Atwood Road #106 Bel Air 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 7-21-1931 New Jersey Director 80 136-22-9000 Usual Residence of Decedent 28a-f show 10a, State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 No Md. Harford Bel Air 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country? Funeral USA 21014 555 South Atwood Road #106 and 2 should be filed within 72 hours after death. Health and Mental Hvniana 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4xxDivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 4yrs Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Leeds James Sagnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arabian Way Fallston, Md. 21047 Charles Bittle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Glen Burnie, Md. 8/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signatur Poeral Service 22. Name and Address of Facility Schimunek Funeral Home 610 West MacPhail Road Be1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Curlinas disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Pregnant at time of death
Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pendina injury s after death. ☐ Accident ☐ Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 32295 angust 5 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MACPHAIL RD SUITE 106 BEL AIR, MD 21014 31. Date filed (Month, Day Registrar's Signatu State Registrar

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	Physicia Medic		GLADYS TOPPER						Month 8	Dav	lo Year	3. Time of D	M M
	Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or		f Death		4c. C	County of Dea		
and the same	<u>/</u>		Univ MD Medical Center			Baltimo					n/a		
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 X F	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth 10/3/1		9. Bir Cc	thplace (State or I untry) 'qinia	Foreign
			Usual Residence of Decedent						10/3/1	740			
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	or 28a	Dire	10e. Street and Number			10f. Zip Code				10a Citiza	en of What Co		ZAJ INO
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Maryland	be file ental H ked o	To E	17. Father's Name (First, Middle, Last) William Bryant Seay						<i>(First, Middle, I</i> Marie K				
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Σ	nd 2 s ealth a m 27 i		John E. Topper / Husband		26B S	hore Road	d, Bal	ltimo	ore, Ma	rylar	nd 2121	9	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State	cem	etery, crem	sition (Name of natory or other place	e)		ate		ation - City or		
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	, I		30. Name and address of person who completed cause of dea	ath (Item 23	Ba) (Type. P		95896	t			8/10/2	oll	
	\		Donald Harris, MD 22			*	B.	altim	ore M	10			_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hygiene Continues of Department Continues of Department											
			Registrar	Certificate of Dear	th		1. No.2 0 1	25812						
	Physicia		1. Decedent's Name (First, Middle, Last) RICHARD F THOMAS		-	2. Date of Death Month	Day Yea	3. Time of Death						
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locat	tion of Death	AUGUST	9 20 4c. County of Do							
-4-40			UNIVERSITY OF MARYLAND MEDICAL CENTER	0			4c. County of D	N/A						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 1 Year Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Ye	9. I	Birthplace (State or Foreign Country)						
	Director		Usual Residence of Decedent	Yrs.		(Month, Day, Ye 10–20	<u>-30 </u>	OH						
	rland f shov d at	tor	10a. State 10b. County N/A 10c. City, Town		imore C			10d. Inside City Limits						
	Mary 28a-1 notifie	Director			THOIE C	тсу		1 🔀 Yes 2 □ No						
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2-0	2 hour "natu edical	Completed	15. Decedent's Education 16a.	Decedent's Usual Occupation (Give kind of work done during	most of workin		b. Kind of Busine	ss industry						
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Maryland 21215-0036	uld be fi 1 Menta marked natic ev	10	Robert A. Thomas		ELiza	beth	Merrick							
, Ma	nd 2 sho ealth and m 27 is i ner traur			Mailing Address (Street and Nu DE. Lee Street	umber or Rural t, Apt	Route Number, Ci 802, Bal	ty or Town, State, timore M	Zip Code) D 21202						
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Disposition (Name of y, crematory or other place) Crematory	8/12/	ı	c. Location - City anover M	·						
Bal	permit Depart Impor any in		21. Signature of Funeral Service Licensee Victor P. D. Cha	2. Name and Address of F. Stern 1501 E. Fort	evens F Avenue,	uneral H Baltimo	ome, Inc re MD 21	2 30						
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× 687	ath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	3 Ectopic pregnancy			23d. Date of	delivery						
Box	he deat y the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			Month	Day Year						
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	()		30. Name and address of person who completed cause of death (Item 23a) (Ty											
	State		DANTE SUFFREDIMI M.D., UNIVERSITY OF MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature	PHLAND MEDICAL C	EMER	22 S. GREE	NE ST. BA	LTMIZE MD ZIZIO						
	Registra	٠ ا	AUG 1 2 2011	harles										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ 201 Maxine Thacker Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Himore Koseda Franklin Square Hospita 8. Date of Birth
(Month, Day, Year)
May 1,1943 Social Security Number **Funeral** If Unde 9. Birthplace (State or Foreign 1 □ M 2 🗶 Kentucky Director 402-58-5183 68 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location death with the Maryland must be notified at 10d. Inside City Limits Director Md. Balto. Nottingham 1 🗆 Yes 2 😾 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 7911 Rolling View Road 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. other traumatic event, the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Cashier Bowling Alley Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Claude Williams Vannie Hughes and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Lloyd Thacker Spouse 7911 Rolling View Road Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Holly Hills 8-13-2011 Middle River, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service I 22. Name and Address of Facilit Schimunek Funeral Homes, Inc 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Preumonia Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed s been significant beautiful to should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 2 X No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: 1 🔲 Yes 2 X No ျှ 1 Inpatient 2 I ER/Outpatient After this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address pleted cause of death (Item 23a) (Type, Print) MD, 9000 Franklin State 12 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Rita Turck AUGUS! 11:00 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Rosedale Baltimore Franklin Square Hospital Center Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 2,1949 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours 212-52-0946 62 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Md. Baltimore Dundalk 1 Yes 2 No Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8115 Bullneck Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married Married altimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2000No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hair Dresser Hair Salon 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Honell Carmella Rizzo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheri Fouts 7741 Fairgreen Road, Dundalk, Md. 21222 Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 10 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 Donation 5 Dother (Specify) 2011 ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, 21 Signature of Funeral Service Livery 21222 23a. Par 1. Inter the disease, or compliminons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic adenocarcinoma resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) has been signed by the real of ☐Yes 2☐No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has al director, page 2: autopsy performed? 1 □ Yes 2 Daylo Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Tes 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident rector: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Laura Steele

31. Date filed (Month, Day, Year) AUG 1 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

586818

Franklin

32. Registrar's Signature

29c. License number

Drive Baltimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene.

		-	1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and IV rtificate of Death		No. 2011 25815							
	Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death							
	Medic Examin	al	Martha Ann Withers 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 1	11, 2011 12:57A ^M 4c. County of Death							
	} Examin	eı	4920 Tartan Hill Road	Perry Hall		Baltimore							
	Funeral Director		5. Social Security Number 214-44-4963 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	g. Birthplace (State or Foreign Country) 1947 Maryland							
	rland f show d at	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits							
	r 28a- notifie	Direc	MD Baltimore Perry 10e. Street and Number	10f. Zip Code	100	1 ☐ Yes 2 ☐XNo Citizen of What Country?							
	with the s 23a o	Funeral Director	4920 Tartan Hill Road	21128		USA							
	death r items iner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.							
036	rs after iral", o Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No 3 ☐ Widowed 4☒ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: white							
15-0	72 hou "natu ledical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing 16	b. Kind of Business Industry							
212	within giene. er thar the N		■ Flementary/Seconday (U-12) ■ College (1-4 or 5+) ■	omemaker		At Home							
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Clarence E. Smith		e (First, Middle, Maio : Irene								
aryl	hould be and Me so mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura	al Route Number, Cit	ty or Town, State, Zip Code) 21128							
ک	and 2 should be file Health and Mental I tem 27 is marked o ther traumatic eve					rry Hall, Maryland							
Baltimore,	- -		4 Donation 5 Other (Specify)	idge Cemetery Aug.16		rimone, Maryland							
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Crematic 8800 Harford Road-Parkville, Maryland Co. Part Service Licensee										
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
- 1	Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ing Cancer		Two Months							
	Examiner			-									
4	ed sit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury										
	cate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
200	ate be physici the bu	edica	d										
Records, P.O. Box 687	ath certific attending for use as	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year							
Ö.	requires that the de been signed by the should be detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?							
ds, l	quires t en sign ould be	ted by			1 Yes	2 No 3 Probably 4 Unknown							
Recor	nysician: The law renis certificate has be	Completed			24a. Was an autopsy performe								
ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outnatient	26. Place of Death (Chec		ce 6 Other (Specify)							
n of V	r Attending Physter death. rector: After this by the funeral d	cate: To	1 Yes 2 No 1 Inpatient 2 ER/Outpatiet 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Inpatient 2 ER/Outpatiet 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury		28d. Describe how								
Division of Vital	I or Attendent after deat Director:	Certificate:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined	creet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)							
٦	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of t	stigation, in my opinion, death occurred a	t the time, date and p	place, and due to the cause(s) and manner stated.							
	To the within To the Comp	2	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)							
)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print\	24	Aug. 11, 2011							
			6569 N. Charles St. Snite 20	() () ()	MD 2	1204							
	Sta Registr		31. Date filed (Month, Day, Year) 32. Right ar's Signature	faile									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 25816 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Year William Howard Ward, Jr. 2212 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗆 F Days 81 Months Hours (Month, Day Year) Maryland **Director** 218-26-7634 1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 🗌 No Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21213 United States 3103 Brendan Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Religious Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev William Howard Ward Sr. Ella Louise Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Ward /Sister 9811 Langs Rd. Apt. C Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory AUG 13,2011 Beltsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Nar@remaitison Familia Funeral Alternatives Kebocca Mac 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Arnh Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$, 11 Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law autopsy 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Tes 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6,2011 042 P200N

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month red 15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore FRANKLIN Sougere Haspital Rosedale 6. Sex 1 **X** M 2 \square F If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Months Hours 08/15/1959 Massachusetts **Director** 020-46-4759 51 Usual Residence of Decedent or 28a-f show 10b. County 10a. State event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 197 Attenborough Drive, Apt. 21237 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 12 if Health and Mental Hygiene. Item 27 is marked other than 1 Elementary/Seconday (0-12) College (1-4 or 5+) Commerical 4 Truck Driver Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303, Baltimore, MD 21237 Joann Beauchamp / Aunt 197 Attenborough Drive, Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ó ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/11/2011 4 X Donation 5 Other (Specify) Anatomy Gifts Registry Hanover, Maryland Signature of Fineral Service Acense 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, of principlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown P.O. signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has e 2 autopsy performe this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 17 No 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending 1 Yes Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29c. License numbe 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md

Registrar
DHMH 17 Rev 7/2009

State

enry Wilson	1.	State of Maryland / Department of Health a - For State Certificate of Death	and Mental Hy		eg. No. 201	1 25818
Physician	1	legistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Deat	h	3. Time of Death 1340 hrs
'alical Examine		Henry Wilson 4a. Facility Name (if not institution, give street and number) 4b. City, Town,	, or Location of Death	Month August 8,	2011 4c. County of Death	
		721 E. 22nd Street Apt. 6			NA	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months E	Year If Under 24Hrs. Days Hours Min.		th(MM/DD/YYYY) 9. Bird Foreig	n MD
Director	L	212-42-8949 1XM 2 F 60 Yrs.		03-02	-43 00	untry) MD
any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and show	ξL	MD NA Baltimore			0g. Citizen of What Cour	1XX Yes 2 No
he Maryland t or 28a-f sh		10e. Street and Number 10f. Zip Cod 721 E. 22nd. Street 212		["	USA	idy:
- 22		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	Hispanic Origin? (Sp		- 14. Race - Ameri	can Indian, Black, African
or item	Lanera	1 Never Married 2 Married 1 Yes 2 No	ban, Mexican, Puerto	Rican, etc.)	Specify: Ame	
ural",	출 -	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occur	upation (Give kind of v		16b. Kind of Business/	
5-0036 led within 72 hours after Hygiene, other than "natural", the Medical Examiner	Сошрівтва	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use reti	red)	Company	
within giene.		12th Grade NA Driver 17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, I	Company Maiden Surname)	
21215-C uld be filed v Mental Hygi marked oth	e l	Wiley Wilson	Mary	W	ilson	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatter.	₽	19a. Informant's Name/Relationship (Type, Print) Lillian Wilson-Wife 19b. Mailing Address (S				
and 2 stealth a steal traum	1	20a. Method of Disposition 20b. Place of Disposition (Name of		Date	20c. Location - City or	
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	ш	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:			Catonsv	
Saltir smit. I epartm nports ijury o		21. Signature of Funeral Service Licensee 22. Name and Add	Iress of Facility W	ylie F	uneral Ho	me P.A.
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy			Baltimore rest, shock, or heart	Approximate Interval
/Medical	Į	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerot				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated eyents resulting in death). Last				
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e be ex ysician	edical	X UNPENDED AMENDED 23a, 27 per me g918 IF FEMALE: 23c. If yes, outcome of pregnancy	8-20-11 V	L	23d. Date of deliver	y
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Box 68760, a death certificate be the attending physici ed for use as the buri	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	***			33
ords, P.O. B w requires that the d s been signed by the should be detached	를 무	Part II. Other significant conditions contributing to death but not resulting in the underlying care	use given in Part I.		tobacco use contribute to	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	5 5 6			24a. Was	an 24b. Were a	utopsy findings available
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tal Rection: The certificate ector, page	<u>ဒီ</u>	25. Was case referred to medical 26.F	Place of Death (Check	L	2 NO 1 V 1	65 2 110
Vita bysicia this ce	Be C	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			Residence 6 Other	er: Scene
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or Attence of Attence death Director:	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, off	fice building, etc.	28f. Location or Town,	(Street and Number or R	ural Route Number, City
Divinal of ours aff	Certification:	4 Homicide determined (Specify)				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the tim (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my op	ne, date and place, and inion, death occurred	d due to the cau at the time, date	use(s) and manner as sta e and place, and due to t	ited. he cause(s)
To To To Com	Med	and manner stated.	icense number	·	29d. Date signed (M	onth, Day, Year)
).C.M.E.		August 9, 2011	
Ø		Name and address of person who completed cause of death (Item 23a) Ling Li, MD	Baltimore, MD 2	1223		
Sta	ate	31, Date filed (Month, Day, Year) 32. Registrar's Signature				
Registr		AUG 12 2011 Cenur A. Janes				

			1 - State Of No.	naryiano / i		tificate of i			gierie Reg. Na	2011	25819
	Physic: /Medi		1. Decedent's Name (First, Middle, Last) TRAIVON JAMES WH	INTE JE	ζ			2. Date of Dea Month	Day	Year 2011	3. Time of Death 5:00 A M
3	Examin Funeral Director	ner	4a. Facility Name (If not institution, give street and numbe SAINT AGNES HOSPITAL 5. Social Security Number 6. Sex. 1X M 2□F	Age (In yrs. last bi	<i>irthday)</i> Yrs.	4b. City, Town, or BALTY (If Under 1 Year Months Days	Location of Death NO RE If Under 24 Hrs. Hours Min.		h y, Year)	Cou	place (State or Foreign intry)
	Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow							10d. Inside City Limits 1 Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 4122 EDMONDSON AVEN			10f. Zip Code	229		10g. Citiz	zen of What Cou	intry?
5-0036	urs after death al", or items 2	b	11. Marital Status 12. Was Deceden Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates	nt Ever in U.S.		/as Decedent of H Yes, specify Cuba □Yes 27No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White, Specify: "BL	
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ryland	should be filed ind Mental Hyg i marked other imatic event,	To Be C	17. Father's Name (First, Middle, Last) TRANOID WHITE 19a. Informant's Name/Relationship (Type, Print)	10)	h	Address (Chroni	18. Mother's Nan	R. C	BENI	2011	in Onda)
ze, ma	es 1 and 2 s of Health an Item 27 is I r other trau		TIMEKA R. BENNETT / MOTHER	20b. Place o	1221	Address (Street and Addres	n avenu	E BALT	20c. Loc	E, m ARY	LAND 2/225 own, State
	permit. Pages 1 Department of I Important: If Ite any injury or ot once.		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	NEW C	ATH 6174 22.	Name and Address	ss of Facility 5	HIST AG	NES		AL
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623	w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death LEFT PNEUMOTHORAX	en in Part I.		obacco us		the cause of death?			
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)	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fr	Medical Cer	29a. Certifler (Check only one) Check only one) 1 Certifying Physician; To the besis and manner s	t of my knowledge of examination ar	e, death	occurred at the tin	ne, date and place pinion, death occu	and due to the	cause(s)	and manner as	stated. to the cause(s)
	To the within To the compl.	Me	29b. Signature and title of certifier	/ 7. ^	-	29c. License	number		4.	e signed (Month	
,	4		30. Name and address of person who completed cause of VRWA V. TORES, WP			rint)		- 5.CA			9 2011 '21229 AITIMORE

Registrar DHMH 17 Rev 1/2001

State

ITOSPITAL S. CATON LUE BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25820 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 13:36 PM RAYON DALIN WHITE 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Hours Min. MARYLAND NONE 0 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 □ No MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò r than "natural", or items 23a or the Medical Examiner must be Funeral 4122 EDMONDSON AVENUE 21229 USA filed within 72 hours after death val Hygiene. d other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: BLACK Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NOINE NONE permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygiel Important: If item 27 is marked other t any injury or other traumatic event the NONE とっこん Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TRAIVON WHITE TIMEKA R BENNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 4122 FDMONDSON AVENUE BALTIMOREMARYLAND TIMEKA R. BENNETT / MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) OCTOBER BALTIMORE NEW CATHEDRAL CEMETARY MARYLAND 7,2011 22. Name and Address of Facility SAINT 21. Signature of Funeral Service Licenses AGNES 900 S. CATON AVENUE BALTIMORE, MARYLAND 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EXTREME IMMATURITY HR 28 MINUTES disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗎 No 3 🗔 Probably 🛂 Unknown RESPIRATORY DISTRESS SYNDROME Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an RIGHT PNEUMOTHORAX autopsy performed' 2 the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral or the funeral o 1. Natural 5 Pending work 1 Tyes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

DHMH 17 Rev 7/2009

only one 29b. Signature and title

31. Date filed (Month, Day, Year

AUG 12

SANTOS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 55 Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Balto. 5714 Station Road White Marsh Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo April 18 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 X M 2 □ F Maryland **Director** 219-01-4571 91 ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. White Marsh 1 🗆 Yes 2 🗆 😽 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5714 Station Road 21162 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed Specify: 3 XWidowed 4 ☐ Divorced Year or Dates. 1943-1945 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Aerospace Co, (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Lockheed Martin 12th Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Weber, Sr. Magdalen C. Kapish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Weber, Jr. 5714 Station Road White Marsh, Md. 21162 Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 8/16/2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR ROAD BALTIMORE, MD 21206 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has bage 2 s autopsy performe death? certificate 2 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: |2 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practional 10 he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) e of Death Physician/ HURVS 2223 Fleetwood Sylvester Wise Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months May 12 Pay, Year 31 Maryland **Director** 215-28-3286 80 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 □ No Baltimore MD 10e, Street and Number P 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 21209 4669 Falls Road items 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify "natural", Completed 3 ¥ Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) car salesman automotive 12 Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 2106 Bryant Ave Apt 1; Baltimore, MD 21217 Dorothy Campbell - niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licenses Wade 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shoo or heart failure. List only one cause on each line Immediate use (Final disease or condition resulting in death) Physician/ shoc Medical Due to fr as a consequence of Examiner vascular discase Sequentially list conditions, if any, Isauing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Year Day 9 Unknown 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performe death? 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending (Month, Day, Year) Division s after death. 1 Yes 2 No Investigation the 3 Suicide 4 Homicide To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) AT 2438946 - BT

State Registrar

30. Name and address of pe

31. Date filed (Month, Day, Year)

KALARIA

NEHA

UNIVERSITY 201 PKWY.

rson who completed cause of death (Item 23a) (Type, Print)

2011

BALTIMORE, MD

			For State Registrar		State of Ma	aryland	d / Depa <i>Cer</i>	artment of I tificate of I	dealth a Death	and Me		giene Reg. No.	011	25823	Ì
	Physicia		1. Decedent's Name		st)		1112	och		2.	Date of Dea Month			3. Time of Death	Λ
,,,,,,,	Medic Examin		4a. Facility Name (if n	not institution, give	street and number)		LNC	4b. City, Town, o	r Location o	of Death	usust	4c. (County of Dea	1771	
-	Funeral		5. Social Security Nur	mber 6. S		(In yrs. la	st birthday)	If Under 1 Year	ORY(Date of Birth		9. Bir	thplace (State or Foreign	n
	Director		217-11-8 Usual Residence of D	3391	□ M 2 🗓 F	84	Yrs.	Months Days	Hours	Min. Ju	(Yy th, P3)	, Year 9:	27 M	aryland	
	yland -f show ed at	ctor	10a. State	10b. County		,	Town or Loc							10d. Inside City Limits 1 X Yes 2 □ No	
	the Mar or 28a e notifi	Dire	MD 10e. Street and Numb	ber		В	altimo	10f. Zip Code				10g. Citiz	en of What Co		0
	th with ns 23a must b	Funeral Director		Aisquith				21202				U	SA 		
9000	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status1 Never Marrie3 Widowed 4		12. Was Decedent E Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates.	ver in U.S. No	11	Vas Decedent of H f Yes, specify Cuba	n, Mexican				4. Race - Ame Black, Whit Specify: b1	e, etc.	
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1212	led within Hygiene. other tha	Be Co	unk 17. Father's Name (Fi		College (1-4 or 5 unk	+)	hot	ısekeepir					omesti	c	
/land	d be filed Mental Hy arked oth	To E	John And								Brown		urname)		
, Maryland 21215-0036	and 2 should Health and Me tem 27 is marl		19a. Informant's Nan Priscil		ype, Print) ell – niec	e	19b. Mailin	ng Address (Street 77 North	and Numbe ourne	r or Rural Ro	bute Number, Baltim	City or T	own, State, Zi MD 21	ip Code) 239	R
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Dispo 1 Durial 2 Surial 2 Donation		Removal from State	20b. Pla ce	ace of Dispo metery, cren	sition (Name of natory or other plac	ce)	Date	•	20c. Loc	cation - City or	Town, State	
Balti	permit. Pag Department Important: any injury o		21. Signat	eral licens	The shre	ctor		. Name and Addre						21201	
I				failure. List only o	plications that caused one cause on each line		. Do not ente	er the mode of dyin	g, such as	cardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death	
الماسيد	Ph_sician/ _Medical		disease or condition resulting in death)	and I	a. Due to (or as a	conseque	ence of):	e ,	1	1			-	Onost and Dodin	111
	Examiner	er	Sequentially list con-	ditions,	b. Ruth	re)		racoalo	Jamil	10 20	ofic 2	new	SM		
	uted nd ansit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or iii that initiated events	ying njury	C.	Conseque	silce oij.						~		
_	cate be executed physician and s the burial-transit	cal E	resulting in death) La		Due to (or as a	conseque	ence of):								
8760	ifficate I	Medical	IF FEMALE:		d							_			
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	onths?	23c. If yes, outcome of the line of the li	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	у			2	3d. Date of de Month	blivery Day Year	
ds, P.O.	requires that the der been signed by the s should be detached	by	Part II. Other signific	cant conditions o	ontributing to death b	ut not resu	lting in the u	nderlying cause gi	ven in Part I		23e. Did to			o the cause of death? Probably 4 🗆 Unknown	n
Division of Vital Records,	rsician: The law re s certificate has be lirector, page 2 sho	Completed		n sees se							24a. Was a autop: perfor 1 Yes		prior to death?	utopsy findings available completion of cause of	
Vital	ysician s certifi director	To Be	25. Was case referred examiner?	d to medical No	Hospital:	ent 2 \square F	R/Outpatien	Oth	er	th (Check on		ence 6	Other (Spec	cifu)	Ш
on of	nding Phy ath. r: After thi e funeral o	Certificate: 1	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	28a. Date of injur (Month, Day	у 2	28b. Time of injury	28c. Injur work	y at	28d	. Describe ho				
Division	al or Atte s after de nl Directo ed in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of Inju building, etc		ne, farm, stre	eet, factory, office		28f.	Location (St City or Town		Number or Ru	ural Route Number,	
_	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of ex se Practioner: To the	amination	and/or invest	igation, in my opinio	on, death oc	curred at the	time, date ar	nd place, a	and due to the	cause(s) and manner state	ted.
	Vith Vith Corr		29b. Signature and til	tle of certifier	1.			29c. License	number	N 60	2	29d. Date	signed (Mont	th, Day, Year)	
				and the same of th	completed cause of de	eath (Item 2	23a) (Type, P	rint)	5-00	10	[(rug	ust	1, 2011	
	Stat	te	Jaimes 31. Date filed (Month AU		2. Registra	r's Signa	O Me C	No Rec 5	xt. 13	altimo	ine, 11	naky	<i>j</i> Land	1, 2011 21257	
	Registra		AU	U 1 & 201	Kengua	المر ر	gar	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G918 8/12/2011 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ YAN CEY Month D& Day 2 Year 6:20 PM N Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSP 89MARITAN GOOD BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Firthplace (State or Foreign 1 **%**-M 2 □ F Min. 215-82-430 Hours Director ary 19na Usual Residence of Deceden show aŧ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MOVA ò 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral U.S. adison 21205 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married 3 Widowed 4 Divorced Black, White, etc. ō by Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. "natural" Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maigen Surname, and Mental Fis marked or 2 other traumatic ance 19a. Informant's Name/Relationship (Type, Pi 50L 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Herbert airwood Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Bal 8-20-2011 ☐ Donation 5 ☐ Other (Specify) em 21. Signature of Funeral Service Licensee A. Name and Address of F Phy 260/0 Service P.A. Balto. 1701 23a. Part 1. Enter the disease, or complications that cau at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shoek eptic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner hem Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events days burial-transit cerra -10 months and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day ☐ Pregnant at time of death☐ Unknown Yes 2 No g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Embolus, Amal florilation Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should mural thrombus, SIP defimual 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 9 autopsy performed EIOH monie this certificate 2 146 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 U No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотретер (Check 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08/10/2011 KES OOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCH RIVEN BALTIMORE BLUD 5601 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signati State 08 Registrar HOG

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH C918 8/29/2011 IH
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			tificate of Deat	th		Reg. No. 2	11	258	25
	Physicia Medic		1. Decedent's Name (First, Middle, L Ruby	E.	1	Brashears		2. Date of Dea Month August	Tay	2011	3. Time of 1 10:30	P M
	Examir		4a. Facility Name (if not institution, gi			4b. City, Town, or Locat			4c. County of Death Frederick			
	Funeral Director		5. Social Security Number 6. 217–28–6338	Sex 7. Age (i	n yrs. last birthday) 78 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. Irs Min.	8. Date of Birth (Month, Day ugust 6,	1933	9. Birthp Coun	olace (State or try) Marylar	Foreign xd
	Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State Maryland Treder		Oc. City, Town or Lo	cation	rick				0d. Inside City	Limits
	with the 23a or 2	Funeral Di	10e. Street and Number 6441 Jefferson Pike	•		10f. Zip Code 2 1	L 7 02		10g. Citizen o	of What Cour States	of Americ	:a
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.)	Nas Decedent of Hispanion of Yes, specify Cuban, Mexicol ☐ Yes 2 No Specify Cuban, Mexicol ☐ Yes 2 No Specify Cuban of Yes 2 No Specify Cuban of Yes 2		cify Yes or No- Rican, etc.)		ace - Americ lack, White, fy: Whi	etc.	
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "natu the Medical	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	Education grade completed) College (1-4 or 5+)	(Give life. D	dent's Usual Occupation kind of work done during O NOT use retired) eteria Manager	most of workin	g	16b. Kind of	Business Inc		
and	be filed viewted Hygrked other	To Be	17. Father's Name (First, Middle, Last George W. Hoffi			18. N		(First, Middle, I	Maiden Surna	me)		
Mary	12 should be file alth and Mental 27 is marked c r traumatic eve		19a. Informant's Name/Relationship Charles Brashears		19b. Mailir 2220	ng Address (Street and Nu Boteler Road,	mber or Rural	Route Number le, Maryl	te Number, City or Town, State, Zip Code) Maryland 21758			
imore,	t. Pa tmer tant ijury		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State	20b. Place of Dispo cemetery, crer Jefferson Un Church	sition (Name of natory or other place) ited Methodist Cemetery	August 201		20c. Locatio	-		
Balt	permit Depart Import any inj		21. Signature of Fuller S S Libe	n e	M01433	Name and Address of Feeney & Bastoro 6 East Church	d P.A. Fo Street,	meral Ho Frederic	me k, Mary	Land 21	701	
المرادية	Ph sician/ Medical Examiner by physician and as the prival-transit as the prival-transi	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	consequence of):	NE dear	XI o				gear	
Box 6	requires that the death certificate. been signed by the attending phy should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No g □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of deliv	_	ear
ls, P.O.	uires that the signed by Id be detact	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause given in l	Part I.	23e. Did to			he cause of dea	
Record	: The law requicate has been	Completed						24a. Was a autop perfo.	sv		psy findings averaged by psychological psych	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use	Certificate: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigat	t 2 ER/Outpatier 28b. Time of injury	nt 3 DOA Other: 4	2	only one) me 5 ☐ Resid			/)		
Division	tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Numbe	ır,
	the Hospi nin 24 hou the Funer ppleted fill	Medical	(Check 2 Medical Exa	nysician: To the best of my miner: On the basis of exa urse Practioner: To the be	mination and/or inves	tigation, in my opinion, dea	th occurred at	the time, date a	nd place, and	due to the ca	iuse(s) and man	ner stated
	To t To t		29b. Signature and title of certifier	>		29c. License numb	516		29d. Date sign	red (Month,	Day, Year)	011
. ∨			ALLEN 76	completed cause of dea	1475	Print) ANE!	AVE	FRI	EREN	ICK	M) 2	1702
	Stat Registra		31. Date filed (Month, Day, Year)	32. egistrars	Signature	arka!						

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		1	For State Registrar	State of Ma	ıryland /	-	irtment of He tificate of De			Reg. No.	1 25826
	Physicia Medic		Decedent's Name (First, Middle, L Virginia	ast) Mae			Brown	n	2. Date of Dea Month	B Day 04	Year 3. Time of Death
	Examin		4a. Facility Name (if not institution, g Meritus Medical				4b. City, Town, or L Hagersto		h	4c. County of Washi	f Death ington
7	Funeral Director	1 1		Sex 7. Age	(în yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h (Year) 1927	9. Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent				ation .		Teb. 20	1, 1, 2, 1	10d. Inside City Limits
	aryland a-f she fied at	Funeral Director	MD Washing	rton	Ha (re)	rstow					1 X Yes 2 □ No
	the M or 28	اق	10e. Street and Number	3COII	nage.	LSLOW	10f. Zip Code			10g. Citizen of Wh	nat Country?
	h with ns 23a nust k	nera	512 Rhode Island				21740				S.A.
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced 	12. Was Decedent Ev Armed Forces? 1 Yes 2 X		If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 X No	, Mexican, Puer	pecity yes of No- to Rican, etc.)		- American Indian, , White, etc. White
21215-0036	"natu edical	Completed	15. Decedent's (Specify only highest		11	(Give k	ent's Usual Occupation of work done du	tion uring most of wo	orking	16b. Kind of Bus	siness Industry
2121	2 should be filed within 72 th and Mental Hygiene. 27 is marked other than " traumatic event, the Mec		Elementary/Seconday (0-12)	College (1-4 or 5-	+)		NOT use retired) maker			Domesti	.c
	e filed value Hyged other event,	To Be	17. Father's Name (First, Middle, Las							Maiden Surname)	
Maryland	ould be nd Men marke matic		Pinkney Gallihe 19a. Informant's Name/Relationship		70	I9b. Mailin	g Address (Street ar	Agnes		r, City or Town, Sta	ate, Zip Code)
	and 2 sh Health ar em 27 is ther trau		Helen L. Golder		1		Mercersb			Spring,	MD 21722
Baltimore,	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3		ceme	etery, crem	sition (Name of natory or other place	i	Date		City or Town, State
altir.	permit. Page Department (Important; If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Lic		Rest		n Cemeter Name and Address		/2011 lest Have	Hagerst n Funera	
m	permi Depar Impol any ir	- 5	> S. Mark	Sunga			601 Penns	-			m, MD 21742
	Physician/ Medical Examiner	J.	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a	consequence	My0 rotic	Cardia,	In	farct tery c	ion disease	Approximate Interval Between Onco and Death, Communication of the Commun
	cate be executed physician and the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):								
68760	cate be physic s the bi	edical	Δ	d							
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal de	eath 3 🗀	Ectopic pregnancy Other (specify)	/		23d. Date Mon	e of delivery hth Day Year
ds, P.O.	requires that th been signed by should be detac	by	Part II. Other significant condition	s contributing to death bu	ut not resultir	ng in the u	nderlying cause give	en in Part I.	23e. Did t		bute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	The law requi	Completed	Epilepsy	/						psy promed? de	Vere autopsy findings available rior to completion of cause of eath?
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to edical examiner? 1 Ves 2 No	Hospital:	ont 2 FR	/Outnatier	26. Pla	r: 4 Nursing		dence 6 🗆 Other	er (Specify)
on of \	ending Phy eath. or: After this he funeral o	Certificate: T	27. Man r of Death 1 V Natural 5 Pending 2 Accident Investiga	28a. Date of injur (Month, Day	y 28	b. Time of injury	28c. Injury work	at		how injury occurre	
ivisi	l or Atter de after de Directo	Certi	3 Suicide 6 Could no 4 Homicide determin		ry - At home . (Specify)	, farm, stre	eet, factory, office		28f. Location (City or To		er or Rural Route Number,
Δ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of extended the practioner: To the basis of the b	camination an	nd/or invest	tigation, in my opinio	n, death occurre	d at the time, date	and place, and due	to the cause(s) and manner stated.
	To the composition of the compos		29b. Signature and title of certifier	MAD Person	ed Ply	Sicia	29c. License	O 4	359	29d. Date signed	(Month, Day, Year) -05-201/
!	3∨		30. Name and address of person w	p completed cause of de	olow	sa) (Type, F	Frenve	Hac	erstown	1, Md.	21742
	Sta Registr		31. Date filed (Month; Day; Year) AIIG 12		ır's Signature	1	arkel			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 25827 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> Physician/ $\overset{ ext{Month}}{ ext{July}}$ Virginia Ann Brubaker 23, 8:45 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11003 Bennington Drive Prince Georges Upper Marlboro Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Oct. 24, 1948 1 🗆 M 2 🕱 F **Director** Pennsylvania 183-38-4573 62 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Md. Prince Georges Upper Marlboro 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11003 Bennington Drive 20774 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professional Singer Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Boczar Sarah Kunkleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Jerry R. Brubaker/Husband 11003 Bennington Dr., Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page Department o Important; If any injury or once, õ 1 X Burial 2 Cremation 3 Removal from State Sept 2011 4 Donation 5 Other (Specify) Arlington National Arlington, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home M00215 2222 Wisconsin Ave., NW., Washington DC 20007 23a. Part 1. Enter the tip ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Uterine Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗆 Yes 2 🗓 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury Medical Certificate: 28b. Time of

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and properties of the funeral director, page 2 should be detached for use as the burial transit. Box 68760 P.O. I Division of Vital Records,

1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury	work? 1 ☐ Yes 2 ☐ No	Edd. Describe	now injury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier		29c. License number $D \infty 69 \ Z$	31	29d. Date signed (Month, Day, Year)			

4715 North 15th Street

<u> Arlington, Virginia 22205</u>

State

JAMES M. SHEAM MD James M. Shear, MD 31. Date filed (Month, Day, Year)

2 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25828 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 26 2011 Month Physician/ 07 11:28 AM Tessie Jewel Buchanan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 Union Hospital ELkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🛣 F Months Hours Min Month, Day, Year) 7/5/1940 **Director** TN 217-38-4387 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12 Glen Creek Circle, Apt B 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Provider Healthcare Home Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mallie K. Putnam Euna Aldright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt B, Elkton, MD 21921 Earl Buchanan Jr. - son Glen Creek Circle, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Garden 08/01/2011 Middle River, MD 21. Signature of Juneral Service Licens 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. Elkton, MD 21921 East Main Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in a chiline. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) owat Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 4 Pregnant 1 ☐ res 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar impleted cause of death (Item 23a) (Type, Print)

200

			Type or Prin					-		.egible.	
	•	For State Registrar		-		rtificate of			Reg. No	1109	25829
Physici /Medio		1. Decedent's Name (First, Middle, Last Carl H. H	30ehme	•				2. Date of De Month	ath Day	Year 201	3. Time of Death 9:37 PM
Examin		4a. Facility Name (If not institution, give	·			2	r Location of Dea	th	4c. County of Death		
-		Anne Arundel Medi 5. Social Security Number 6. S			Annapolis rs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bi					nne Arı	
Funeral Director			X M 2□ F	89	Yrs.	Months Days	Hours Min		ay, Year)	22 of	thplace (State or Foreign Dustrict Columbia
Maryland a-f show	tor	10a. State 10b. County MD Anne Ar	undel	10c. City	y, Town or Lo	cation llersvill	.e				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 28s	al Director	10e. Street and Number 8404 Adler Co	urt			10f. Zip Code 211	08		-	en of What Co	puntry?
be filed within 72 hours after death with the Maryland trail tyglene. d other than "natural", or items 23a or 28a-f show event, I'm Medical Evantier i unt be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub- 1 ☐ Yes 2 X No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		4. Race - Ame Black, Whit Specify: V	
within 72 horene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired ne Shop I	during most of wo d)	orking	i .		Industry t of the
d d d	To Be Co	17. Father's Name (First, Middle, Last) Paul Boehme			raciii	ne bhop i	18. Mother's Na	ame (First, Middle Berkows	, Maiden S	4	
i, Mal ylally and 2 should be eath and Mental n 27 is marked er traumatic ev		19a. Informant's Name/Relationship (** Paul John Boehme				ng Address (Street		Rural Route Numb			•
permit. Pages 1 and 2 should I bepartment of Health and Men Important: If item 27 Is marke any injury or other traumatic.		20a. Method of Disposition 1 Magazial 2 Cremation 3 4 Donation 5 Other (Specification 2)	Removal from State		lace of Dispo emetery, crer	osition (Name of matory or other place coln Ceme	ce) Tul	Date Y 27, 2011	20c. Loc	ntwood	Town, State
permit. Departm Importa any Inju		21. Signature of Funeral Service Licen	See	-	Ba	Name and Address PS Ritchi	Sons, F	A. Seve	erna l	Park Fu	uneral Home MD 21146
Dhusisian		23a. P. 11. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	olications that caused one cause on each lin	the death	n. Do not ent	ter the mode of dyi	ng, such as cardi	ac or respiratory a	ırrest,	uzny .	Approximate Interval Between Onset and Death
Physician /Medical Examiner	disease or condition resulting in death) a. Ulu Mujoca radial Infant Clush Due to (or as a consequence off)										
xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequ	uence of):						
cian cian puria	_	that initiated events resulting in death) Last C. Due to (or as a consequence of): d									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the tental or the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal	Ideath 3	☐ Ectopic pregnand	су		2	23d. Date of de Month	elivery Day Year
signed by	þ	Part II. Other significant conditions of	-		_	nderlying cause giv	en in Part I.	23e. Did		,	o the cause of death?
The law requate has been page 2 shoul	Completed	Demente	mell mell	ter	-3			24a. Was auto perfo	psy ormed?/	24b. Were a prior to death?	
ician: Sertific ector,	Be (25. Was case referred to medical examiner?	Lleonitel			104		eath (Check only	one)		
Phys rthis ral dir	.T	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier 28b. Time o	nt 3 DOA Oth	4 LI Nursing	Home 5 ☐ Res 28d. Describe		- ' '	ecify)
tending leath. for: After the fune	Certification:	11 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Da	y, Year)	Injury	M 1 E	k?]Yes 2 □No				
ital or At Irs after or ral Directilled in by	Certifi	4 Homicide determined	building, et	c. (Specify	y)	eet, factory, office		City or To	wn, State))	lural Route Number,
the Hosp iin 24 hou the Funei	Medical	29a. Certifier (Check only one) (Check only one)	ysician: To the best niner: On the basis o and manner sta	of my kno f examina ated.	wledge, deat tion and/or in	h occurred at the to exestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) , date and	and manner a place, and du	as stated. e to the cause(s)
To 1 To 1	Σ	29b. Signature and title of certifier	Mis			29c. Licens	5 7 5 3 <i>j</i>		Jul Jul	e signed (Mon	th, Day, Year) 2011 MD 21108
50		30. Name and address of person who	completed cause of d	eath (Item	1 23a) (Type,	Print)	Hay	Mille	، در در	u	mh 21108
Sta Registr		31. Date filed (Month, Day, Year) JUL 2 8 20	32. Registr	ar's Signa	ture	4	"J , '			,	
OHMH 17 Rev 1/2	001	30L & 0 20	Com	-	1. 190	ura					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25830 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July ΑM Danny Lawrence Beavers 0723 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 353 Nottingham Road E1kton Ceci1 6. Sex 1 X M 2 □ F Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours DEC 30, Year 952 West Virginia Director 232-88-8279 58 Usual Residence of Deceden or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 275 is marked other than "natural", or items 23a or 28af sho ther than "natural", or items 23a or 28af sho ther than the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 353 Nottingham Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1972

1 X Yes 2 No 1975

If Yes, Give 1975 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1975 1 Yes 2 X No Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Safety Manager Chemical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Dewey Beavers Martha Deloris Casteel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Joy Beavers/Wife 353 Nottingham Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ju1v 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery Elkton, MD 21. Signat e of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death hetata Ph_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to increasing cause. Enter Underlying Examine Due to (or as a consequence or). or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown pinous peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy certificate Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this nin 24 hours after death.

The Funeral Director: After thin pleted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined To the Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Number Pradition on To the best of my however, and the time date and place, and due to the cause(s) and manner stated cortifying Number Pradition on To the best of my however, and the time date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cau death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Mary		epartment of F Certificate of L			Reg. No. 0 1 1	25831
	Physicia	n/	1. Decedent's Name (First, Middle, Last Raymond Err.	est Carro	oll			2. Date of Dea Month July	Day Year 25. 201	
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, o	r Location of Death	IJULY	4c. County of De	
	1		Anne Arundel Med			Annap			Anne Ar	
	Funeral Director		219-40-6450	7. Age (In	yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Feb. 26	r, Year) C	sirthplace (State or Foreign Country) Lryland
	ind show at	l. 1	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	Maryla 28a-f otified	Director	MD Anne Aru	ndel	Arn	olđ 				1 ☐ Yes 2 💢 No
	with the s 23a or ust be n	Funeral D	10e. Street and Number 16 Beechwood Road	Ē		10f. Zip Code 2101	2		10g. Citizen of What C	Country?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	1965– 1969	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, hite, etc. White
Baltimore, Maryland 21215-0036	in 72 hou e. nan ''natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	ucation de completed) College (1-4 or 5+)		Decedent's Usual Occup 'Give kind of work done life. DO NOT use retired)	during most of work	king	16b. Kind of Busines	
7	d with Hygien ther ti nt, the	l as l	12 17. Father's Name (First, Middle, Last)			Installer	19 Mother's Nam	ne (Eiret Middle	Communica Maiden Surname)	ICTORS
auc	be file lental l rked o rked o	일	Raymond E. Carro	ll, Sr.				an Dorse		
lary	should and M is mal		19a. Informant's Name/Relationship (Ty)	SISCE		Mailing Address (Street				Zip Code)
e, ⊾	and 2. Health em 27 ther tr		Jacqueline H. (Tr			6 Beechwood Disposition (Name of			D 21012 20c. Location - City	or Town State
imor	Page 1 ment of l tant: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	MD	v, crematory or other pla Veterans	Cemetery ^J	uly 29, 2011	Crownsvil	
Balt	permit. Depart Import any inj		21. Signature of uneral Service License		MU	21. Name and Addre Barranco 495 Ritc	& Sons, hie Hwy,	P.A. Ser	verna Park verna Park	Funeral Home MD 21146
Į	25a. art 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate vause (Final disease or condition and are the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate vause (Final disease or condition and death) and the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line.							rest,	Approximate Interval Between Onset and Death	
age of the	Medical Examiner	(disease o condition resulting in death)	a. Due to (or as a co	nsequence o	n:				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence o	ŋ:				
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence o	f):		-		
200	ate be physicia the bur	edical		d						
Box 687	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of Month	delivery Day Year
Division of Vital Records, P.O.	es that the signed by t be detac	b	Part II. Other significant conditions co	ntributing to death but n	ot resulting in	the underlying cause g	iven in Part I.			to the cause of death?
cords	aw requir as been 2 should	Completed						24a. Was	osy prior t	autopsy findings available to completion of cause of
Re	: The k							1 🗆 Yes	ormed? death	? Yes 2 🗆 No
/ital	sician certifi irector	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ EB/Out	26. F	Place of Death (Chec		dence 6 Other (Sp	anciful
n of V	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye	28b. T	ime of 28c. Inju jury wor	ry at		now injury occurred	веспу)
ivisio	or Atten after dea Director: in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		m, street, factory, office		28f. Location (S City or Tow	Street and Number or syn, State)	Rural Route Number,
	Hospital 24 hours Funeral eted fillec	Medical	(Check 2 Medical Examin	ician: To the best of my ner: On the basis of exam e Practioner: To the bes	ination and/or	investigation, in my opin	ion, death occurred	at the time, date a	and place, and due to the	ne cause(s) and manner stated.
	To the within To the compl	2	29b. Signature and title of pertifier	Bech, C		29c. Licens			29d. Date signed (Mo	nth, Day, Year)
	5x1		30. Name and address of person who c	ompleted cause of death		ype, Print) Park	way ann	apolis, 1	rup .	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2820	32 Rehistrar's	Signature	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Certificate of Death Reg. No. 20 2583	2
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) James Alton Cockrell 2. Date of Death Month Day Year 1903 hrs	
mearear Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
	Nabbs Creek Rd @ Francis Road Glen Burnie Anne Arundel	_
Funeral Director	5. Social Security Number 213-76-5393 6. Sex 1 Number 52 Yrs. 7. Age (In yrs. last birthday) 52 Yrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or O6/21/1959 Foreign Mary Land Country)	
yas y	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	ts
and show	MD Anne Arundel Pasadena 1 Yes 2 XN	lo
the Maryland a or 28a-f show any itified at once. Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 A Mountain Road 21122 USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of that and Mental Hygiens the Matural", or items 33a or 28a-f tho Important. If item 27 is marked other than "natural", or items 33a or 28a-f tho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1	
is after ural", miner	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry	
5-0036 ed within 72 hour 1/9 giene. other than "matu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
0036 within piene. Medic	12 Owner Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	<i>7</i>
21215-0036 Muld be filed within 7 Muntal Hygiens marked other than c event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Alton Cockrell Helen Martin	
D 21.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 sho ealth and traumat	Mary Cockrell / Wife 209 A Mountain Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	_
nore ages 1 nt of H nt: If in	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify Metro Crematory, INC. 2011 Baltimore, MD	
Baltimore, cemit. Pages I ar Department of He Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Hom	 n_
	495 Ritchie Hwy, Severna Park, MD 21146 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interve	
Physician Medical	Gailure. List only one cause on each line. Between Onset and Death	
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Blunt Force Injuries Due to (or as a consequence of):	_
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_
0, be executed sician and ourial - transit edical Examiner	cause Enter Underlying Cause (Disease or injury that initiated	_
nd ransit	events resulting in death) Last Due to (or as a consequence of): d.	
O, e be exec visician a burial - I	UNPENDED AMENDED	
	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
b. Box 6876 the death certificate death certificate by the attending phyched for use as the Physician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
D. Be	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	_
, P.(1 Yes 2 No 3 Probably 4 Unknown	
ords w requi s been should	24a. Was an autopsy findings available autopsy prior to completion of cause of	
Records, The law requires ficate has been sig, page 2 should be	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Division of Vital Records, P.O. Is or Attending Physician: The law requires that the start death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach stiffication: To Be Completed by Priffication: To Be Completed by P	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Was 2 No. 2 N	_
n of Vi ding Physi After this funeral di	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	_
sion trendi death. ctor: A y the fu	1 Natural 5 Pending Investigation State Accident Investigation Pending Investigation 1846 hrs 1 Pe	
Division o or Attending hours after death. neral Director: After filled in by the filme Certification:	3 Suicide 6 Could not be determined Coperation and Suicide 4 Homicide Specify Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Nabs Creek Rd @ Francis Road, Glen Burnie, MD	У
To the Hospital within 24 hours To the Funeral completely filled	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	_
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 24, 2011	
	30. Name and address of person who completed cause of death (Item 23a)	_
101	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
DHMH 17 Rev 1/2001	ORIGINAL	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death August 4, Day 2011 Year Physician/ 12:37 AM Guy Donald Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hancock 12737 Long Hollow Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours (Month, Day, Year) 02/20/1925 **Director** 162-22-1564 PA 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21750 12737 Long Hollow Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event; the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Stone/Brick Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Flora Mills Raymond Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12737 Long Hollow Road Hancock, MD 21750 Lorraine L. Clark/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer U.M.Cemetery 08/06/2011 Needmore, PA 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 and M00260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Congestive Head Failure disease or condition 1 year Medical resulting in death) Due to (or as a consequence of Examiner Rende CHROWIE V ears Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit STENOS 15 HORTE Severi that initiated events Due to (or as a consequence of) resulting in death) Last To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached 9 Hinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director A

28c. Injury at work? Natural Accident (Month, Day, Year) 5 \square Pending 1 Tes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) menego en Nalan 15 00065518

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marilyn Nelson, M.D. 131 N. Pennsylvania Ave. Hancock, MD 21750

31. Date filed (Month, Day, Year) State

AUG 1 2 2011

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary		artment of H			iene eg. No 20		25834
	Physicia		Decedent's Name (First, Middle, Last) Thomas Henry Chase				2. Date of Deat Month August 1	th	Year	3. Time of Death 2:33 р м
_	Medic Examir		4a. Facility Name (If not institution, give street and number) St. Mary's Hospital		4b. City, Town, or I			4c. County St. N	y of Death	
Ġ	Funeral Director		219-34-9724 1 M ≥ □ F	yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 13,		9. Birthp Count M	
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County 10 MD Saint Marys	c. City, Town or Loc			_		1	0d. Inside City Limits 1 ☐ Yes 2 🎜 No
	h the M ka or 28 be noti	Funeral Director	10e. Street and Number	Lexington	10f. Zip Code		1	10g. Citizen of	What Coun	
	ith wit ms 23 must	ner	21412 Great Mills Road	- 110 T40 1	20653		aif. Van au Na	USA		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fu	11. Marital Status 1 Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates.	li li	Vas Decedent of His f Yes, specify Cuban ☐ Yes 2 🌁 No	, Mexican, Puerto	ecity yes or No- Rican, etc.)		ce - America ck, White, e	
Baltimore, Maryland 21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	lent's Usual Occupat kind of work done du O NOT use retired) Ne\		Ĭ	16b. Kind of B	lusiness Inc	lustry
/land		To Be	17. Father's Name (First, Middle, Last) Joseph Chase Sr.	1		18. Mother's Nam Hazel Ke		faiden Surnam	e)	
, Man			19a. Informant's Name/Relationship (Type, Print) Brindle Hutchins - Niece		ng Address (Street ar D. Box 341,			City or Town, S	State, Zip C	Code)
timore			20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Young's C	hatory or other place hurch Ceme	tery Augu	st 9, 2011	20c. Location Huntingt	own, N	· ·
Ball	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P. 1451 Dares Beach Rd., Prince Frederick, MD								78	
F	hysician/		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	death. Do not ente	er the mode of dying,	such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
1	Medical Examiner	Jr.	Sequentially list bonditions,	ria						minutes
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a cor	DONASCO	ular 1	Disease				years
09	ate be executed bhysician and the burial-transit	dical	resulting in death) Last Due to (or as a condition of the condition of th	isequence oi).						
. Box 687	ath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
ls, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.				e cause of death?
Division of Vital Records,	ine law req ate has bee page 2 shot	Completed by	i				24a. Was ar autops perforn 1 \sum Yes 2	ned?	Were autop prior to cor death? 1 ☐ Yes	osy findings available mpletion of cause of 2 No
<u>a</u>	iysrolan; The is certificate director, pag	Be (25. Was case referred to medical examiner? Hospital:			ce of Death (Checi				
<u> </u>	rnysi this c ral dir	2	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien 28b. Time of	t 3 DOA Other	4 ☐ Nursing Ho	me 5 Reside			
sion o	trending death. stor: After the fune	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	er) injury	M 1 □ Y	es 2□No	28d. Describe ho			D
DIVIS	io the rospital or Attending Fri within 24 hours after death. To the Funeral Director, After thi completed filled in by the funeral		4 Homicide determined 28e. Place of Injury - building, etc. (Sp.	ecify)			28f. Location (Str City or Town	, State)		
1	vithin 24 hc To the Function	Medical	29a. Certifier (Check only one) 1	nation and/or investi	igation, in my opinion	, death occurred at time, date and place	the time, date and e, and due to the	d place, and du cause(s) and m	e to the cau anner as sta	ise(s) and manner stated.
	5 × 6 0	Muchael Vet 068427 August 1							†	, 2011
21			30. Name and address of person who completed cause of death Michael Person V	O Bo		Leon	weston	1, Me	0 2	0650
	Stat Registra		31. Date filed (Month, Day, Year) 32. Figistrac's S	ignature A	ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ F. 0600 Louis Donoway 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rehabilitation + Nursing Ctr lisburu Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Min. Hours (Month, Day, Yea 7-22-192 Mary Land Director 214-12-5929 90 Usual Residence of Deceden show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 X No Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6860 Cherry Walk Road 21830 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 194

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 □ No 1942-Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 1945 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George В. 01ive Donoway White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, <u>Deborah Wood - Daughter</u> 6860 Cherry Walk Road, Hebron, Maryland 21830 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gd 7-30-2011 Hebron, Maryland Signature of Furteral Service Licer 22. Name and Address of Facility Bounds Funeral Home Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or constshock, or heart failure. List only or ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) onsequence of **Examiner** Sequentially list conditions, if any hading to immediate cause. Enter Underlying Examiner requering of, attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the all d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes ☐ Yes eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural work? 5 Pending 2 🗌 No ☐ Accident ☐ Sulcide Investigation 6 Could not be 24 hours after deat Funeral Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed within 2 3 [Certifying Nurse the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 7/2009

William

31. Date filed (Month, Day, Year)

H. Robin

M.D

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25836 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2126 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegani Social Security Number 6. Sex 9. Birthplace (State or Foreign Country), MD If Under 1 Year If Unde 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗖 M 2 🗆 F Min. Months **Director** 216-74-9442 50 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11700 Old Valley Road 21502 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Interstate Waste sanitation and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vernadine M. Lee Richard D. Dicken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Department of Health an Important: If item 27 is r. any injury or others. Sandra Dicken wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 8/8/2011 MD Cumberland 4 ☐ Domation 5 ☐ Other (Specify) 22. Name and Address of Facilities at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1/ Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ORONARY 4THEROSCLEROS disease or condition Medical resulting in death) Examiner PERLIPIDE Sequentially list conditions, in any, reasons to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events OBACCO resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 12 1 🗌 Yes 1 Inpatient 2 K ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) fter this 28a. Date of injury (Month, Day, Year) filled in by the tuneral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours ar er deat Funeral Director: 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0036371 2011

State Registrar

DHMH 17 Rev 7/2009

KELLY RO CUMBERLAND

621

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAMMOND BANFER MO

31. Date filed (Month,

11-05796 Jason Todd Dolan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

lason Todd Do	lan	State of M 1-For State Registrar	laryland / Depa Ce	artment of ertificate of		Mental H	_	201	1 2583
Physic Medical Exam		Decedent's Name (First, Middle, Last)	odd	Dolan			2. Date of Dear Month August 2,		3. Time of Death 1200 hrs
		4a. Facility Name (if not institution, give stree 13318 Moores Hollow Road	t and number)		4b. City, Town, or Lo Cumberland	ocation of Death		4c. County of De Allegany	ath
Funeral Director		5. Social Security Number 6. Sex 219-98-2936 1 M 2	7. Age (In yrs.	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min		th(MM/DD/YYYY) 9. 6, 1980	Birthplace (State or eign Country MD
and show any	ا اة	Usual Residence of Decedent 10a. State 10b. County MD Allegan		, Town or Locat	nberland				10d. Inside City Limits 1 Yes 2 XNo
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 13318 Moores Hollo			10f. Zip Code	21502	10	0g. Citizen of What C	ountry? SA
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "matural", or items 23a or 28a-f ahe t, the Medical Examiner must be notified at once	by Funeral		Vas Decedent Ever in U urmed Forces? Yes 2 X No Give Year	If Y	s Decedent of Hispa es, specify Cuban, N	Mexican, Puerto		White, etc	nerican Indian, Black, hite
5-0036 led within 72 hours & Hygiene. I other than "natura the Medical Exami	Completed b	15. Decedent's Education (Specify only high	est grade completed) ollege (1-4 or 5+)	during m	t's Usual Occupation ost of working life. D	O NOT use reti		16b. Kind of Busines	
21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First Middle, Last) Ronald Robert H. Dolan 19a. Informant's Name/Relationship (Type, Pr	int \			Mother's Name. Lore	tta C. Ri	laiden Surname)	
MD and 2 should be alth and and 1 is 27 is 3 is 3 is 3 is 3 is 3 is 3 is 3 is	T ₀	Loretta Dolan 20a. Method of Disposition	mother	10	03 Virginia	a Avenu	Date	imberland	MD 21502
Page Page nent ant: or otl		1 Burial 2 Cremation 3 Rer 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	moval from State	crematory or oth arpelli Fur		P.A.	8/4/2011	Cresap	
Balt permit. Depart Import injury		23a. Part/I. Enter the disease, or complication	s that caused the death		Scarpel	lli Funeral	ue Cumbe	rland MD 215	02 Approximate Interval
/M igal Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Intra-	oral Gunshot Wou (or as a consequence o	ınd	,,,,,				Between Onset and Death
	iner	rause Enter Underlying Cause	(or as a consequence o	of):					
executed an and al - transit	I Examiner	(Disease or injury that initiated C.	(or as a consequence o	of):					
60, tte be exe hysician a	Medical		NDED If yes, outcome of pregi	nancy				23d. Date of deliv	erv
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Live birth Pregnant at time of de Unknown	2 Fet	al death 3	Ectopic pregna	ncy	Month	Day Year
i, P.O. E ires that the d signed by the	Ŕ	Part II. Other significant conditions contrib	outing to death but not re	esulting in the u	nderlying cause give	en in Part I.			to the cause of death?
cords law requi has been 2 should	Completed						24a. Was a autope perform 1 ✓ Yes 2	sy prior t m <u>ed</u> ? death	
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	1 Inpatient 2	ER/Outpatient	100	Death (Check of her Nursin		Residence 6 🗸 Ott	ner: Scene
tion of tending Ph death.	ertification: 1	1 Natural 5 Pending 2 Accident Investigation	a. Date of Injury (Month, Day,Year) ug 2, 2011	28b. Time of Ir 1130 hrs	1 Yes	2 🗸 No	28d. Describe h Subject shot	ow injury occurred self	
Division To the Rospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O	4 Homicide determined (S	e. Place of Injury - At ho	nily Home			or Town, SI 13318 Moores	ate) Hollow Road, Cur	
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the							
	Σ	29b, Signature and title of certifier	>		29c. License n			29d. Date signed (A August 4, 2011	
PV		30. Name and address of person who complete Ling Li, MD Assistant Medical	Examiner 900	W. Baltimore		ore, MD 21	223		
St Regist	ate	31. Date filed (Montage, 1eg 2011	32 Registrar's Signatu	1. par	Les Car				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 18:25M Deter Elizabeth Ann Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland <u>420 Maryl</u>and Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) PA Months Days Hours Min. Month, Day Y Dec 27 Director 214-80-7598 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County at 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s Injury or other traumatic event, the Medical Examiner must be notified Allegany Cumberland MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 420 Maryland Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ KNo Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. Specify. 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>homemaker</u> own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Bassinger Thomas Havthorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Deter 420 Maryland Avenue MD 21502 husband Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Øfernation 3 ☐ Removal from State 8/5/2011 Scarpelli Funeral Home, P.A. 4 Donation 5 Other (Specify) MD Cresaptown 22. Name and Address of Facility
Scarpelli Funeral Home, PA uneral Service Ligensee any 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ auabetesmeilitus disease or condition Wyrs Medical resulting in death) Due to (or as a consequence of) Examiner apertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner ue to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? ☐ Yes 2 ☑ No certificate 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ After this of funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the Last of my knowledge could be the cause (s) and transfer as stated. Signature and title of certifie 29c. License number Kimbellymaynard Cmp-t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Kimberk

31. Date filed (Month,

/Maynard

Day, Year)

621 KellyRoad Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harvey Stuart EPSTEIN July 1:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Kensington <u> 10007 Stoneybrook Drive</u> 8. Date of Birth (Month, Day, Oct. 17 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 577-64-9978 Months Hours Min. 64 946 Washington, DC Yrs. Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Kensington Maryland Montgomery Ξ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 20895 10007 Stoneybrook Drive death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify white Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) should be file h and Mental H is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ Nora Schreiber Murray Epstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10007 Stoneybrook Drive, Kensington, MD 20895 Rita Klein, Spouse 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/31911 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance Memorial Park Clarksburg, MD Funeral Service Licensee Forechinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 20 MOTHT Pnysician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami fransit B To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 pding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Year Pregnant at time of death Day 2 No ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Thromboembolic Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) July 29, 2011 29c. License number D 35996

State

Registrar

2730 University Blvd., #400, Wheaton, MD

20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Linda Burrell,

JUL 29

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25840 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Margaret West Filer 10·10 P M Medical 08 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Talbot Hospice House Easton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-31-1922 6. Sex Funeral Age (In yrs, last birthday) 9. Birthplace (State or Foreign 1 M 2 F Days Hours North Carolina 89 205-16-0777 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Midlothian Allegany 1 Yes 2 No 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code 23a Funeral Ŭ.S.A. 20003 Old Midlothian Rd. 21543 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No 9 Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3 ₩Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Sollege (1-4 or 5+) Elementary/Seconday (0-12) Office/Clerical Stenographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Robbins Corliss Catherine Cecelia Loughery Corliss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3841 Rumsey Dr. Trappe, MD 21673 Walter Filer Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-07-2011 Frostburg Mem Park Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 60 W Main St Frostburg, MD 21532 Man DWE13 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnag 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d Date of delivery in the past 12 mon 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? this certificate 2 🗀 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the Funeral Director: upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day. Year) 3rd D0070409 who completed cause of death (Item 23a) (Type, Print) State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month :36 A.M 31 2011 William Frame /Medical Charles 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany <u>Lions Center</u> Cumberland 8. Date of Birth (Month, Day, Year) Feb 25, 19 Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 ☐ F Director 1921 215-12-2466 90 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the Medical Evantone must be notified at Director MD Cumberland 1 ☐ Yes 2 ☐ No Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21502 USA 901 Seton Drive death v by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 □Yes 2 📉 No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced WW II white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Glass Company 12 Owner / Operator and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Charles Robert Frame Julia Mooney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Johnson MD 21502 813 Highland Avenue Cumberland daughter 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ **X** emation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 8/2/2011 MD Cresaptown 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncarrying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s certificate has b irector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 🗌 No within 24 hours after death To the Funeral Director; completely filled in by the f 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Box 68760.

P.0.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0026907

Bishop Walsh Road Cumberland MD, 21502

Physician/ Medical Katherine Krents - Spouse

Examiner

and and physician a sthe burial-1 nin 24 hours after death.

the Funeral Director: After the repleted filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	20a. Method of Disposition 1 Burial 2 Cremation 3 Remov					Date 20c. Location - City of			or Town, State	
	4 ☐ Donation 5 ☐ Other (Specify)			Crematory	07/27/	2011	Br	entwood,	, Maryl	.and
	21. Signature of Funeral Service Licenses	med	22. Nan 1180	ne and Address of Fac 0 New Hamp	shire A	s-Rino Ive.,	ıldi Silv	Funeral er Spri	Home, .ng, MD	Inc. 20904
ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	s that caused the death e on each line. Metastati Due to (or as a consequenc	Do not enter the .c. Melano ence of):	mode of dying, such a					Approximat Interval Bet Onset and f	e ween
by Physician/Medical	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1								Day	Year eath?
completed by	Depression					1 🔲			Probably 4 🗶 Unknown	
COMP						autor	rmed?	prior to death?	completion of c	ause of
e n	25. Was case referred to medical examiner?			26. Place of De	eath (Check on	ily one)				
0	1 ☐ Yes 2 🕱 No	l: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 [□ DOA Other: 4 □ 1	Nursing Home	5 X Resid	dence 6	Other (Speci	ify)	
ricate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Sulcide 6 □ Could not be	i. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work?	28d	I. Describe h				
al Cert	4 Homicide determined 28e.	. Place of Injury - At hor building, etc. (Specify)		ctory, office	28f	Location (S City or Tow		Number or Rur	ral Route Numb	per,
Medic	29a. Certifier 1 X Certifying Physician: To (Check 2 Medical Examiner: On only one) 3 Certifying Nurse Pract	the basis of examination	and/or investigatio	n, in my opinion, death	occurred at the	time, date a	nd place,	and due to the o	cause(s) and ma	nner stated.
-	29b. Signature and title of certifier Joceline Kou	atcheu,	mis	29c. License number				e signed (Month July 24		

Jocelyne Youkep Kouatchou, M.D., 201 East University Parkway, Baltimore, MD 21218

July 24, 2011

6010 Onondaga Road, Bethesda, Maryland 20816

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL **2** 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0155 FRAL ORGE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2606 Chapel Lake Drive Anne Arundel Gambrills 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Egypt Months Min Hours 0674374924 87 187-64-5927 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Gambrills MD Anne Arundel 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21054 2606 Chapel Lake Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Yes 2 No within 72 hours after 1 Yes 2 No Specify: Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "rany injury or other traumaria. than " Elementary/Seconday (0-12) College (1-4 or 5+) Banking Banker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Abdalla Geballa Wedad Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3513 Victoria Lane, Davidsonville, MD 21035 Marc G. Geballa/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Columbia Gardens Cem. 07/29/2011 Arlington, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death lock, or heart failure, L only one caus Immediate Cause (Final Physician/ MENI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) MANDRIA 2 PINO 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No ___ Accident Investigation within 24 hours after deatl To the Funeral Director, Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Estifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) woo completed cause of death (Item 23a) (Type, Print) VICUE LIGHTFOOL I

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25844 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month July 25, 2011 11:00a M Raymond /Medical Hi11 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Nursing & Rehabilitation Ctr Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, May 13, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 🔯 M 2 🗆 F North Carolina 245-20-8636 Director May Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinatment be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Clinton 1 Yes 2 □ No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 √ Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: 2 Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Doorman Hotel 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Richard Hill Bessie Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie L. Parker/Brother in Law 7705 14th Street, N.W. Washington, D.C. 20012 20b. Place of Disposition (Name of cemptery, crematory or other place)
Mary's Chapel Baptist
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/30/2011 Scotland Neck, NO 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, DC 20012 tann 23a. P. d. Enter the disease, or complications that caused the d. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each II e. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Right foot ulcer Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsecuence of: sician and burial mans Peripheral Vascular Disease Due to (or as a consequence of): Physician/Medical Diabetes Mellitus the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery ģ 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign I be <u>Hypothyroidism</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 □ Yes 2 □No 2X No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

law requires that the death certificate be executed P.O. Box 68760, Records, The Division of Vital Physician: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

attending physician

has

certificate

After this

Baltimore, Maryland 21215-0036

determined 4 T Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29a. Certifier

Medical

29c. License number D0025640

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khosrow Davachi, M.D. 7801 Old Branch Avenue #409, Clinton, MD 20735

and manner stated.

31. Date filed (Month, Day, Year)

29 2011



2

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 919 9-15-11 vt. State of Maryland Poepartment of Health and Mental Hygiene State Registrar 25845 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Anna G. Physician/ J_{uly}^{Month} ^{Day} 2011 27 Anna Marie Hanlon aka Anna Gentile Hanlon aka Hanlon 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Collingswood Nursing Center Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🗆 M 2 🗓 F Days Hours Min. **Director** 047-22-3468 81 Nov. Connecticut Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 United States 20404 Hancock Bridge Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceden... Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ hours after Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry عد filed wn. ۱۹۰۰ Hygiene. ۱۳۰۰ Than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygier 7 is marked other t Computer Programmer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Guiseppe Gentile Philomena Ceto other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 20404 Hancock Bridge Place, Montgomery Village 20886 John J. Hanlon/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Lawrence Cemetery 08/02/2011 4 ☐ Donation 5 ☐ Other (Specify) West Haven, CT 21. Signature of Funeral Servi licenses 22. Name and Address of Facility 10 East Deer Park Drive 1 RACE MO1117 DeVol Funeral Home Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Leukemia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examil To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ing physician as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Por Month Day Pregnant at time of death the 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 2 💢 No 4 X Nursing Home 5 - Residence 6 - Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral v 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 💢 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0068890 July 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 299 Hurley Avenue, Rockville, MD 20851 Summit Gupta, M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

JUL 29 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9927 5-11-12 vt. State of Maryland 7 Department of Health and Mental Hygiene Reg. N. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician dith 2200 M Haverstic 2011 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns HOPKI NS 7057+A mos 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 ☐ M 2 🗶 F 83 Yrs. Director 14, 1927 Nov. PA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Medical Examiner must be notified at any Injury or other traumatic event, Item Medical Examiner must be notified at 1 ☐ Yes 2 X No Director PA Lancaster Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Water Leaf Rd. 17603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Edward Rankin Ida Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James S. Haverstick/ Husband Water Leaf Rd. Lancaster, PA 17603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/11/2011 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Willow St. Mennonite Cem. Willow Street, PA 22. Name and Address of Facility. Gundel Funeral Home, Inc. 415 North Duke St. Lancaster, PA 17602 21. Signature of Funeral Service Licensee uch ang Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final organising PNEUMONIA **Physician** ryptogenic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the burial Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 □ Yes 2 □ No certificate 1 ☐Yes 2 ☐ No Division of Vital r this certifica ral director, p 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mD RES-000

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MNIESSE

32. Registrar's Signature

H+CM, 31. Date filed (Month, Day, Year)

2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 25847 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death July Physician/ 20 11 Alan R. Jones 26° 3:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gambrills Anne Arundel 1103 Red Harvest Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F (Month, Day, Year, North Carolina 79 Yrs Director 243-44-6761 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Gambrills Anne Arundel 1 Yes 2 No MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? by Funeral USA 21054 1103 Red Harvest Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White Year or Dates. 1951-54 Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Federal Government Attorney at Law Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) marked ဂ္ Polly Mullens Alan W. Jones and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 1103 Red Harvest Road, Gambrills, MD 21054 Mary W. Jones/Spouse 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/30/2011 | Baltimore, Maryland Metro Crematory Signature of Funeral Service Lices 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or comp calions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Dancreatic cancer Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Be Completed by Physician/Medical Box 68760 IF FFMALE signed by the attending the detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N this certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No e Hospital or Attending Pt n 24 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year)

Registrar

Stuart

2003 medical Parkway, 31. Date filed (Month, Day, Year) JUL 2 8 2011 32. Registrar's Signature

selonick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-05622 Alexandra Kiriakou Please

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20	25848
State of Maryland / Department of Health and Mental Hygiene	23040

		1- For State Registrar	Certificate of	f Death	Reg	g. No.			
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Alexandra Ki	riakou		2. Date of Death Month July 27, 20	Day Year	3. Time of Death 2014 hrs		
		Facility Name (if not institution, give street and number) 1909 Henry Road		4b. City, Town, or Location of Rockville	of Death	4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 X F	(In yrs. last birthday) 78 Yrs	Months Days Hours		(MM/DD/YYYY) 9. Birth Foreign Cou			
d sow any		Usual Residence of Decedent 10a. State 10b. County 1 Maryland Montgomery	Oc. City, Town or Locat		ville		10d. Inside City Limits 1 Yes 2 X No		
death with the Maryland r items 23a or 28a-f show aust be notified at once.	Director	100. Street and Number 1909 Henry Road		10f. Zip Code 2085	10	g. Citizen of What Count			
ore, MD 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 22s or 28s-f she her frammatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 2		res, specify Cuban, Mexican,		14. Race - Americ White, etc.			
72 hours afte m "natural"; al Examine:	eted by	3 X Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+	during m	Yes 2 X No specify: nt's Usual Occupation (Give loost of working life, DO NOT		Specify: 16b. Kind of Business/In	White		
21215-0036 Muld be filed within 72 hou Mental Hygiene. marked other than "nat e event, the Medical Exa	Completed	1 2 17. Father's Name (First, Middle, Last)		Homemaker 18.Mother	s Name (First, Middle, M	aiden Surname)	1 Home		
2121 nould be fill ind Mental I is marked	To Be	Kiriakus Katsiger 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street and Num	ber or Rural Route Numb				
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental it: If item 27 is marked other traumatic event,	10 (5)	Fotini Bazekis - Daughter 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Dispos crematory or oth		Date	20c. Location - City or T	Town, State		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Parklawn I	Memorial Pk. Name and Address of Facility	07/30/2011 Hines-Rina	Rockville ldi Funeral	, Maryland Home, Inc.		
Physician		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral H 11800 New Hampshire Ave., Silver Spring 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line.							
Examiner		Immediate Ceuse (Final disease or condition resulting in death) A Head and Neck II Due to (or as a consequence)					Death		
2	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and immaked	10000						
m and T transit	ledical Exa	events resulting in death) Last Due to (or as a conseq d	uence of):						
Box 68760, death certificate be execute the attending physician and the for use as the burial - trans	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth 4 Pregnant at tir	2 Fe	stal death 3 Ectopic	pregnancy	23d. Date of delivery Month Da	ay Year		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. When Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by Physician	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death by				pacco use contribute to the			
ords, P w requires the second of the significant of the significant of the significant of the significant of the second of the s	Completed b				24a. Was ar eutopsy	y prior to co	opsy findings available ompletion of cause of		
Vital Records, hysician: The law requir this certificate has been s I director, page 2 should I	Be Com	25. Was case referred to medical		26.Place of Death	perform 1 Yes 2 Check only one)		2 No		
Nysici Pysici Trbis c	70 E	examiner? 1 Yes 2 No Hospital: 1 Inpatient				tesidence 6 🗹 Other:	Scene		
Division of tall or Attending Ples after death. In Director: After led in by the funeral led in by the funeral		27. Manner of Death 1	FOUND: 2011 hrs	1 Yes 2 ✓	No Fall	ow injury occurred			
Division To the Hospital or Atterwitin 24 hours after des To the Functal Directo	Certification:	4 Homicide determined (Specify) Sing	le Family Home	et, factory, office building, etc	or Town, Sta 1909 Henry Ro	reet and Number or Rura ate) oad, Rockville, MD			
To the Hospital within 24 hours To the Funeral completely filled	Medical	29d. Certifying Physician: To the best of my kone) 2 Medical Examiner: On the basis of examinand manner stated.			curred at the time, date ar		cause(s)		
3	177	Carol Hella	lu.	O.C.M.E.		July 28, 2011			
		Name and address of person who completed cause of dea Carol Allan, MD	ner 900 W. Balt	timore Street, Baltimo	re, MD 21223				
S Regis	tate trar	31. Date filed Worth Cap Year 2011	Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 Physician/ July 20 Sally Ann Kraus 10:01aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Montgomery 8300 Burdette Road. Apt. A541 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🛍 F Months Days Min 74 Director 132-34-5189 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location must be notified at 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20817 U.S.A. 8300 Burdette Road, Apt. A541 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 0 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3 Widowed 4 X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Social Worker Therapy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Rosiland Light Manuel Kraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6448 Western Star Run, Clarksville, Maryland 21029 Wendy Abramson - Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🕱 Cremation 3 🗌 Removal from State Lincoln Crematory 07/26/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Signature of Funeral Service Licensee MBMAN MO 1524 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Malignant Pulmonary Neoplasm Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 X Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed' 2 X N 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this pempleted filled in the control of the cont 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X. Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) H45839 July 20, 2011 completed cause of death (Item 23a) (Type, Print) Gary E. Raffel, D.O., FACP, 5413 West Cedar Lane, Suite #203C, Bethesda, MD 20814

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 E. Kay A M Jacqueline 4:00 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park Sunrise Assisted Living If Under 1 Year If Under 24 Hrs. Social Security Numbe . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours Min (Month, Day, 032-18-5427 84 1926 Massachusetts **Director** Usual Residence of Decedent show 10a. State 10d. Inside City Limits with the Maryland 10c. City. Town or Location notified at Director 28a-f MD Anne Arundel Severna Park 1 Yes 2X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 21146 USA 43 W. McKinsey Road Apt. 238 er than "natural", or items the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 24 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. United States Elementary/Seconday (0-12) College (1-4 or 5+) Tour Guide Naval Academy Department of Health and Mental Hyg Important, If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Esther Murphy John Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Haskell Drive Arnold, MD 21012 <u>Virginia Mirenzi</u> / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State
☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD 4 Donation Metro Crematory, INC: 2011 21. Signature of Funeral Service Licenses Farranco & Fsons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 23s. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia Cause (Final uisea – or condition resulting in death) Onset and Death Se Ph_sician/ OSIS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? or Attending Physician: The law requires that the death Pregnant at time of death Month Dav Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical

State

29a. Certifier

(Check only one

29b. Signature and title of

3

JUL 2 8 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schmidlein

32. Registrar's Signatu

Registrar

DHMH 17 Rev 7/2009

Ritchie

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00030741

Suik 204 Severno

29d. Date signed (Month, Day, Year)

WD JIH

29c. License number

		Please Type or Pri			_		
	-	For State of M State of M Registrar	-	artment of Health a rtificate of Death		giene Reg. 2011	25851
Physicia Medic		1. Decedent's Name (First, Middle, Last) William Frederick Kas	lick, Sr.		2. Date of De Month August		3. Time of Death 7:30 PMM
Examin		4a. Facility Name (If not institution, give street and number) Somerford Assisted Living		4b. City, Town, or Location of Frederick	of Death	4c. County of Dear	ck
Funeral Director		499-26-4102 1 ₹ M 2 □ F	e (In yrs. last birthday) 82 yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bir Min. July 4	9. Bir 9. 1929 Mis	thplace (State or Foreign untry) S OURI
aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or Lo				10d. Inside City Limits 1 Yes 2 No
with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 6134 Springwater Place,	Unit H	10f. Zip Code 21701		10g. Citizen of What Co	puntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Department of Heath and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent to Armed Forces? 1 □ Yes 2 ▼ If Yes, Give Year or Dates.	No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 ☐ Yes 2 ☐ No Specify:	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
within 72 hou giene. er than "natu , the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired) ICE Officer	t of working	16b. Kind of Business Law Enfore	
ild be filed Mental Hygnarked oth latic event,	To Be	17. Father's Name (First, Middle, Last) Frederick C. Kaslick		М	er's Name (First, Middle, ary Mulvehi	.11	
nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Mary E. Kaslick, daughter	19b. Maili 923	ing Address (Street and Number 9 Ridgefield C	er or Rural Route Number Circle, Fred	derick, MD	ip Code) 21701
Page 1 ar ment of He a nt: If ite r ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponent Competers, cressing this but	osition (Name of matory or other place) rg Crematory A	ug. 8, 2011	20c. Location - City of L Smithsbu	
permit. Depart Import any inj		21. Signature of Funeral Service Licensee	M00255	2 NKeeneyresandei 106 East Chur	Masford PA lach St., Fre	Funeral Hom ederick, MD	e 21701
hysician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	9.	ter the mode of dying, such as	1	rest,	Approximate Interval Between Onset and Death
Medical Examiner		Due to (or as	a consequence of				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	a consequence of):				
cate be executed physician and the burial-transit	1— 1	resulting in death) Last Due to (or as	a consequence of):				
tificate ing phy as the	Med	IF FEMALE:					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
ures that the signed by the si	by	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause given in Part	I. 23e. Did t	obacco use contribute t	o the cause of death? Probably 4 ☐ Unknown
he law req te has bee age 2 shou	Completed				24a. Was auto perfe 1 □ Yes	psy prior to death?	utopsy findings available completion of cause of
cian: 1 sertifica ector, p	Be	25. Was case referred to medical examiner?			th (Check only one)		
r Physical this ceral dir	e: To	27. Manner of Death 28a. Date of inju		of 28c. Injury at		dence Other (Spe	Living
ttending death. tor: Afte	Certificate:	Natural 5 ☐ Pending (Month, Da. 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	y, Year) injury ury - At home, farm, st	M 1 ☐ Yes 2 ☐		Street and Number or Re	ural Pouta Number
oital or A urs after rral Direc		4 - Horricide determined building, etc	c. (Specify)		City or To	vn, State)	
ne Hosp in 24 ho he Fune pleted f	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of a Medical Examiner: On the basis of a Certifying Nurse Practioner: To the	examination and/or invest	stigation, in my opinion, death o	ccurred at the time, date	and place, and due to the	cause(s) and manner stated
vith Com		29b. Signature and title of certifier	MO	29c. License number	421	August 8,	
/		30 Name and address of person who completed cause of cames AMCCAG 909	leath (Item 23a) (Type,	elc(An#104	Frederick	MD21	701
Sta Registra		31. Date filed (Month, Day, Year) 32. AUG 1 2 2011	ar's Signature	n Kil			
IH 17 Rev 7/20	009	- Jane	1				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Juana July 27 Day 2011 Year Diaz Lopez 0818 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birt 9. Birthplace (State or Foreign 1 M 2 X F Hours 34/201/1979 **Director** 32 none Guatemala Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Beltsville MD Prince George 1 Yes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13004 Bellevue Street 20705 Guatemala 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, et Guatemalan 0. Black, White, etc þ 1 Never Married 2 K Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 I and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Napoleon Diaz Guerra Maria Reynelia permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edy Diaz/Brother 13004 Bellevue Street Beltsville,Md 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Saspan Chiquimula, Guatemala General Cemetery 8/05/2011 4 Donation 5 Other (Specify) Signatur PHYTOP ADDES RINALDI FUNERAL SERVICE, P.A. uneral Service Lic Me 9241 Columbia blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Cays Immediate Cause (Final Ph_sician/ Metastatic pleural effusion disease or condition Medical resulting in death) Examiner Malignant ovarian cancer years Sequentially list conditions, Physician/Medical Examiner cause (Disease or linjury Due to (or as a consequence oi): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): use as the buria physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 XNo for Pregnant at time of death Month be detached ed by the Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ asthma, malnutrition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performe After this certificate 2 K No 1 Yes 2 🗌 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural injury 5 Pending work' 2 🗌 No Accident 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature d title of certifie 29d. Date signed (Month. Day, Year) 10 005/630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun MD 1500 Forest Glen Rd Silver Spring, Md 20910

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JUL 29 2011

Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

29 2011

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 26, Evelyn S. Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sanctuary at Holy Cross Burtonsville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours Min July 10, 578-14-6952 Director 91 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location MD Montgomery Silver Spring Ö 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10306 Ridgemoor Drive 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Sobotka Edna Sheaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Martin/Son 46822 Planters Court, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 30 July Cedar Hill Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2011 21. Signature of Funeral Service Licensee Francis Address Colins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a Colon Cancer

28a. Date of injury (Month, Day, Year)

Due to (or as a consequence of):

Physician/ Medical Examiner

Immediate Cause (Final

25. Was case referred to medical

2 X No

5 Pending

nd title of certifie

Investigation 6 Could not be

determined

1 Yes

1X Natural

2 Accident
3 Suicide
4 Homicide

29a. Certifie

(Check only one 29b. Signa

30. Name and address of perso

Manner of Death

disease or condition resulting in death)

Examine e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial regions. Physician/Medical Completed by Be မ Certificate:

P.O. Box 68760

Records,

Division of Vital

Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linijury that initiated events resulting in death) Last	Due to (or as a consequence of): C		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition Osteoarthritis	ns contributing to death but not resulting in the underlying cause given in Part I. Hypertension		o use contribute to the cause of death?
		24a. Was an autopsy performed;	

28c. Injury at

🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work?
1 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D002534

29c. License number

26. Place of Death (Check only one)

2 No

Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

July 28, 2011

 $201 \, {\mathring{I}}^{\text{ear}}$

Montgomery

14. Race - American Indian,

Black, White, etc.

_{Specify}White

Own Home

4c. County of Death

1920

USA

ам

4:30

9. Birthplace (State or Foreign

D.C.

10d. Inside City Limits 1 🗌 Yes 2 🔀 No

MD 20901

Approximate Interval Between Onset and Death

2 months

State Registrar

Medical

Robert Ginskerg, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 29 201

3905 National Drive, #220, Burtonsville, MD 20866

who completed cause death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 25855 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8:00 P M Minchin July Monica Ann 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, 54 Maryland 214-72-2477 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 🏋 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 64 Old South River Rd. #7 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White etc 1 Never Married 2 X Married Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Danie1 Brookman Woods Carol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendall T. Minchin, Sr./Husband 64 Old South River Road #7 Edgewater, MD 21037 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place; 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 7/27/2011 Edgewater, MD of Funeral Service License 21. Signat 22. Name and Address of Facility George P. Kalas Funeral 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part . Enter the disease, or complicate shock, or heart failure. List only one day ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 4890 disease or condition resulting in death) cano Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Day Year e cause of death?

Ph sician/ Medical **Examiner**

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

notified at

ms 23a or must be n

ed other than "natural", or iter event, the Medical Examiner

al Hygiene.

and Mental is marked

Department of Health at Important; If item 27 is any injury or other trainone.

other traumatic

Baltimore, Maryland 21215-0036

items 2

Director

Funeral

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Completed

Be

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Exami Physician/Medical ģ

IF

and -trar physician a the burialsigned by t Completed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn Be 은 Certificate:

To the Hospital or Attending Physician; The law requires that the death certificate be executed

peen

Division of Vital Records, P.O. Box 68760

FEMALE: B. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of c	elivery Day	Year
art II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute		
		24a. Was an autopsy performed?	prior to death?	completion	ings available of cause of

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 🗶 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 379 29d. Date signed (Month, Day, Year) 25 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Bestgate Road, Suite 300, Annapolis, MD 21401 Jay Rhee, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year)

JUL 2 8 2011

Amend #26 per PHY 7/27/2011 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AA Co. Health Dept. lo State of Maryland / Department of Health and Mental Hygiene 25856 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Moore Bettu JUL 2011 7:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Min. 212-28-1354 Hours 2/13/1930 Country) 81 Director TN Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Anne Arundel Severn 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral items 23a 230 Burns Crossing Road 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o 1 Never Married 2 Married ģ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) I 2 College (1-4 or 5+) Nursing Aid Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Tivis Bell Elsie Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important; If item 27 is any injury or other trau Sharon Foster (daughter) 1197 Coulbourn Corner Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 7/27/2011 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 851 Annapolis Rd Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner obstructive pulmonan Sequentially list conditions. Examiner il any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trans Due to (or as a consequence of resulting in death) Last Physician/Medical Osteoauttmosis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director, After 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one attending 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 056950 July 22, 2011

State Registrar Nnaemeka

31. Date filed (Month, Day, Year)

1441 Madison

Orive Smite 16 Hen Brmie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma State Registrar	aryland / Depa <i>Cer</i>	artment of Hea tificate of De		ental Hygie Reg	2011	25857
Physician/			David Michael McCracken				2. Date of Death Month Jul v	Day Year 25 2011	3. Time of Death 3:46 P M
Medical Examiner			4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Cente		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
	Funeral Director		5. Social Security Number 421−82−8423 6. Sex 1 🔀 M 2 🗆 F				8. Date of Birth (Month, Day, Ye June 21	9. Biri 1957 Mas	hplace (State or Foreign untry) sachusetts
	Aaryland 8a-f show tified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland	10c. City, Town or Loc	cation Riv	7a			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
re, h	with the N s 23a or 2 ust be no		10e. Street and Number 3081 Riverview Road		10f. Zip Code	21140	10g	. Citizen of What Co	
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, 3 Year or Dates.	No	Nas Decedent of Hispa f Yes, specify Cuban, № I ☐ Yes 2 X No S		ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: W	
	vithin 72 hou iene. i r than "nat i the Medica		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-4)	(Give F	dent's Usual Occupatio kind of work done durir O NOT use retired) Incial Anal	ng most of working	g	b. Kind of Business	
	d be filed v Aental Hyg Irked othe Iic event,		17. Father's Name (First, Middle, Last) Mahlon McCracken			B. Mother's Name Maryann			
	2 ∃ 2 1 1 1 1 1 1 1 1 1 1		19a Informant's Name/Relationship (Type, Print) Nancy Allyn McCracken/wife	19b. Mailin 3081	ng Address (Street and Riverview				
	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place) Crematory	i .		c. Location - City or Len Burni	Town, State e, Maryland
Balt	permit. Page Department of Important: If any injury or once,		21. Signatura Truneral Service Licensee	Lu 14	Name and Address of Duke of	of Facility Joh Gloucest	n M. Tay er St.,	lor Funer Annapolis	al Home , MD 21401
in, P	hynician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition		er the mode of dying, s		respiratory arrest,		Approximate Interval Between Onset and Death
THE !	Medical Examiner	_	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						3 days
kecuted n and al-transit			if any, leading to immediate cause. Enter Underlyin. Cause (Disease or iinjury that initiated events						
0	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last Due to (or as a	consequence of):					
68760	ing phy e as the		IF FEMALE:	,			-		
P.O. Box (ne death ce y the attend ched for us	Physician/M	in the past 12 months?	2 months? 1 Live Birth 2 Petal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month				23d. Date of de Month	livery Day Y ear
Js, P.O	urres mar r in signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.				-		
Records,	ine law rec ate has bee page 2 sho	Completed					24a. Was an autopsy performer 1 Yes 2	prior to	topsy findings available completion of cause of
ta .	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital:		_ Other	of Death (Check of			
Division of Vital Records, P.O. Box 68760 al or Attending Physician: The law requires that the death certificate be executed is after cleath. In Director, After this certificate has been signed by the attending physician and all bire the funeral director, page 2 should be detached for use as the burial-transit.		cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Natural 5 Pending	y 28b. Time of injury	28c. Injury at work?		ne 5 Residence Bd. Describe how i	e 6 Other (Specinjury occurred	ify)
ivisio	after dea Director: Lin by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injubuilding, etc	et, factory, office 28f. Location (St		8f. Location (Stree City or Town, S	treet and Number or Rural Route Number, n, State)		
	vo the nospital or within 24 hours after To the Funeral Dir. completed filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
,	Withi To th		29b. Signature and title of certifier		29c. License nu	ımber		Date signed (Monti	
	. 16		30. Name and address of person who completed cause of de	eath (Item 23a) (Type F	H0070		7	125/1	
	20	W Keith Gover 2000 medial Parkney Angeoty mo 21401							
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 8 2011 22. Registra	s's Signature	K)		, 31		

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 10:35 PM Physician/ ETHEL McC 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ALLEGAN FROSTBURG HOME ETZOSTB 4/2G VILLAGE NURSING 5. Social Security Number Z13 - ZZ - 314 7. Age (In vrs. If Under 1 Year | If Under 24 Hrs. 6. Sex last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔭 F (Month, Day, **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director -205 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a KAYLOR ONE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ò 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: WHIT "natural", Completed 3. ₩idowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOME injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MURPH ပ္ DURS JAMIE 19a. Informant's Name/Relationship (Type, Pript) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar.
Important: If item 27 is u WOODCOCK HOLLOW RD. MT. SAVAGE, MD DAUCHTER 12801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other p RESTLAWN MEM ZOU a VALE 4 Donation 5 Other (Specify) SSEVIC 21. Signature of Funeral Service Licensee NIG WWAY LAVALE, MI) NATIONAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ Cards disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine as a consequence of Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 De No
9 Unknown Month Day Year Pregnant at time of death ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😭 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 **N**0 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) : After thi 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural Accident 5 Pending thin 24 hours after death.
the Funeral Director: Aft
mpleted filled in by the fur Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

HARJIT S. SI
31. Date filed (Month, Day, Year)

925 BISHOP

WALSH R.D. CUMBERLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.M. NHOIZ. 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25859 8/9/11;BW,Mcc Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Ruth G. Neipris 2. Date of Death Day 2011 Physician/ July 3:26 p M 25 -Ruth Neipris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8100 Connecticut Avenue, Chevy Chase Montgomery 5. Social Security Number If Under Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Min Hours **Director** 193-36-3894 06 Massachusetts Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20815 8100 Connecticut Avenue, #607 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 X Married ğ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify. 3 Widowed 4 Divorced Caucasian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Psychiatric Social Work Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ဂ Philip Goldman Fannie Rotman Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilmington, Delaware 19803 Perth Road. Jonathan Neipris - Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 5 cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 07/28/2011 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Lieensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
3 Months Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes Yes pleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗶 Residence 6 Nother (Specify) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 26, 2011 D0052509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Sue Kanter,

31. Date filed (Month, Day,

M.D.,

Year

29 2011

6410 Rockledge Drive,

#308, Bethesda, Maryland 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERNA ARLENE NAVE 4 , Da 2011 Year AUG. 5:39A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CLINTON PRINCE GEORGES SOUTHERN MD. HOSP CENTER Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) **Funeral** 1 M 2 XF Months Days 79 WASH., D.C. 220-46-1739 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director UPPER MARLBORO 28a-f MD. PRINCE GEORGES 1 Yes 2X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 12101 VAN BRADY ROAD 20772 U.S.A, items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Was Deceden 2vo. Armed Forces? 1 \(\sum \) Yes 2\(\overline{X} \) No Black, White, etc. ò þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 'natural", Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working life, DO NOT use retired) MALCOLM GROWHOSPITAL than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha U.S.GOVT. SECRETARY 12th injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN TRUMAN RAWLINGS ERNA SCHWIEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12101 VAN BRADY RD. UPPER MARLBORO, MD. f Health a item 27 i THURMAN O.NAVE-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date 1 Burial 2 Cremation 3 Removal from State CHELTENHAM UNITED METH.CEM 8-9-11 CHELTENHAM, ND 4 Donation 5 Other (Specify) Signature of Funeral Service Licer M-0047 RAYMOND FUNERAL S LA PLATA, MARYLAND SERVICE, P.A. D 20646 23a. Part 1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ voca disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physician ad for use as the burial. Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year per the P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 No 1 Yes Yes 2 1 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Mann**a**f of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated cattifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complet only one 29b. Signature and title completed cause of death (Item 23a) (Type 30. Name and address o

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per INF G918 8/17/2011 JH State of Maryland / Department of Health and Mental Hygiene 25861 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2215 M 27 2011 41 /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
D.C. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔀 F 77 July 4, Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot amy injury or other traumatic event, the "Accident Event nor reat but natified at once. 1 ☐ Yes 2 ☒ No Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6600 Seneca Farm Road U<u>SA</u> 21046 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: <u>≽</u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Marion Collins Joseph Hogan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael O'Neill/Son 3318 Sang Road, Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Church
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 20I1 4 ☐ Donation 5 ☐ Other (Specify) Bowie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aortic stenos.s disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner regurgitati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. oronan ar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 🕅 ves 2 🗆 No 3 🗆 Probably 4 🗀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
11. Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 🗆 No 2 Accident neral Director: , filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier MD 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 N. WOLFESTREET, BALTIMURE, MO 21287

DHMH 17 Rev 1/2001

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Year)

29 2011

31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15 34 Month PO Medical if not insti tion, give street **Examiner** 4c. County of Death Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1**XX**M 2 □ F Months Min 8/28/1985 Days 212-11-5970 25 Yrs **Director** DC Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director · 28a-f 1 Yes XXX No MD Anne Arundel Churchton 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 5706 Bayview Pkwy USA 20733 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. White Specify. 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Potts Christina Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father 5706 Bayview Pkwy Churchton, MD 20733 Michael Potts other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2011 Lady of Sorrows West River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 905 Galesville Rd. Galesville, MD 20765 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not inter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions weeth if any, leading to immediate cause. Enter Underlying as a consequence of) Examin CERTIFICATION APPROVED BY MEDICAL EXAMINER 02 or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trai resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown Yes 2 No ed by the a g 🗌 Unknown P.O. signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been signated by page 2 should by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examine . 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home_ 5 ☐ Residence_ 6 ☐ Other (Specify this : After thi 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d Describe haw injury occurred 1 Natural Accident 5 Pending work death. n 24 hours after death.

Pe Funeral Director: Af oleted filled in by the fu Investigation 6 Could not be lace of Injury - At home, farm, stre building, etc. (Specify) factory, office 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07-24-2011

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	State of Mary		artment of H tificate of L			ene _{9. N} 201	1	25863
			Registrar 1. Decedent's Name (First, Middle, Last)			incate of E	Journ	2. Date of Death		•	
	Physicia Medic		Armando E. Porzil	llo Jr.				July 23	, 2011	Year	3. Time of Death 2139 M
	Examin		4a. Facility Name (if not institution, give str	eet and number)			r Location of Death		4c. County o		
grap!			940 Blue Ridge Dr			Annapo If Under 1 Year		Tab. (B)	Anne		
	Funeral Director		5. Social Security Number 6. Sex 103–42–8750	M 2 □ F 7. Age (In)	vrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth 0/4/1087/1	954	B forts	NY NY
			Usual Residence of Decedent								
	yland -f shc ed at	Director	10a. State 10b. County		City, Town or Loc					100	d. Inside City Limits
	e Mar r 28a notifi	Sire	MD Anne Aruno	iei	Annapoli			T			1 Yes 2 No
	ith th	rail	940 Blue Ridge Di	rive		10f. Zip Code 21409)	10	ng. Citizen of Williams USA	hat Countr	y?
	ems	Funeral		. Was Decedent Ever i	n U.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		- Americar	ı Indian,
ထ္ထ	ter de , or it		1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 🕅 No			an, Mexican, Puerto	Rican, etc.)		, White, et	
8	rurs a' tural" al Exe	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		☐ Yes 2 🔀 No			Specify:	White	
15	72 ho n "na fedic	nple	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	lent's Usual Occup kind of work done (O NOT use retired)	during most of worl	king 1	6b. Kind of Bus	siness Indu	stry
77	vithin jene. rr tha	S	Elementary/Seconday (0-12)	College (1-4 or 5+) 01		ntractor			Sto	one M	ason
פַ	filed val Hyg	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma			
<u>X</u> a	ild be Menta narked artic e	욘	Armando E. Porzill	o Sr.			Joseph	ine Russ			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Dolly May Grimes Po			g Address (Street Blue Ridg	and Number or Rui ge Drive	ral Route Number, C Annapoli	City or Town, Sta Ls, MD 2	ate, Zip Co 1409	de)
Baltimore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Db. Place of Dispo cemetery, cren Atlantic	sition (Name of natory or other place Cremator	e) 08/0		Oc. Location - G	-	
Balti	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Fundal Service Licensee	11	22 Ha	. Name and Addre	ss of Facility Suneral He	ome P.A.	12 Ride Annapol	ely is,M	Ave 21401
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	death. Do not ente	r the mode of dyin	ıg, such as cardiac	or respiratory arres	t,		Approximate
~F	h_sician/		Immediate Cause (Final disease or condition	A CUTE	GAST	ROINTE	STINIC	HEMMI	PHAGO	= 3	nterval Between Onset and Death
	Medical Examiner		resulting in death)								5 3/0 =
		e.	Sequentially list conditions, b.					LIVER		_	5 yes
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a con	otalice oi).	STEA	TOHEP,	ATITE	5		ZOYRS
	execur in and iaf-tra		that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):						
09	death certificate be executed ne attending physician and ed for use as the burial-transit	dical	d.	MORB	10 01	BESIT	7				
687	rtifica ling ph e as tl	/Me	IF FEMALE:								
Box (ath certifica attending p for use as f	cian,	in the past 12 months?	 If yes, outcome of predictions Live Birth 2 ☐ Pregnant at time 	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date Mon	e of deliver th E	y Day Year
M	y the a	Physician/Me	1	9 Unknown	e or death 3 L	Other (specify)					
9. 0.	requires that the de been signed by the should be detached		Part II. Other significant conditions contr	4	t resulting in the u	nderlying cause gi	ven in Part I.				cause of death?
ds,	quire; en siç ould b	ted	17/E 2 VI	1BETES				1 🗆 Yes	s 2 □ No 3	3 🗌 Proba	ably 4 Unknown
Ö	law re nas be e 2 sh	Completed by	ELEVATED	L) 1/103				24a. Was an autopsy	pr	rior to com	y findings available pletion of cause of
ž	: The Is cate ha		_					1 Yes 2	No 1	eath?	No
<u>ta</u>	ysician: iis certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		Oth	lace of Death (Chec				
<u>></u>	Physer this eral di	e: To	27. Manner of Death	28a. Date of injury	2 ER/Outpatien 28b. Time of	t 3 L DOA 28c. Injur	4 ☐ Nursing H	ome 5 Resider 28d. Describe how			
on C	ath. r; After ie funer	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Yea	r) injury	work	⟨? Yes 2 ☑ No				
Division of Vital Records,	ipital or Atteno ours after deat eral Director; filled in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location (Stre City or Town,		r or Rural F	oute Number,
Ξ	spital o		29a. Certifier 1 Certifying Physici	an: To the best of my k	nowledge, death o	occured at the time	a, date and place, a	nd due to the cause	e(s) and manner	r as stated	
	to the Hospital or Attendating Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	On the basis of examin	ation and/or invest	igation, in my opinio	on, death occurred a	at the time, date and	place, and due	to the caus	e(s) and manner stated.
	5 wit		29b. Signature and title of certifier	1	Lin	29c. Licens	5621	29	d. Date signed	(Month, Da	ay, Year)
			30. Name and address of person who com	nleted cause of death	(Item 23a) (Type P	rint)	0		01/2		40
1/	43		30. Name and address of person who com	5 M.D.	24018	PANDE	RMILL B	LVD, 25	O, GA	MBR	IUS 21054
	Stat	е	31. Date filed (Month, Day, Year) JUL 2 8 201	32. Redistrar's S		6.41		,	1		
	Registra		JUL 2 0 401	1 Dunner	1 a. A	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 25864 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 5:20 A M Dolores Potocki July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 836 Creek View Road Severna Park Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 Days Min 212-30-8398 May 08, 1931 **Director** Maryland Usual Residence of Decedent items 23a or 28a-f showner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 836 Creek View Road 21146 USA n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide Education 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Kraus Regina Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen West / Daughter 225 Ackerman Road Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park Glen Burnie, MD 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ar Icin son's Ph_sician/ Medical resulting in death) **Examiner** 10 months Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of -transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 9 Unknown 9 Unknown us been signed by the 2 should be detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 autopsy performed? Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian nefer 122 11k 210

State Registrar 31. Date filed (Month, Da

L 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 2011 1:25 Рм Perry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Village at Harbor Pointe Salisbury Wicomico 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Min. (Month, Day, Year, 7-26-1925 New Jersey Months Hours Director 149-16-4746 86 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32815 Dagsboro Road 21849 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 W Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene
Important: If item 27 is marked other the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Rossell Marv Bever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Morgan - Daughter 32815 Dagsboro Road, Parsonsburg, Maryland 21849 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 7-29-2011 4 ☐ Donation 5 ☐ Other (Specify) <u>Wicomico</u> Memorial Pk Salisbury, Maryland 21. Signature of Fureral Service Ligensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 First 1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List card one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) ^{*}Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Exam resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending plants the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 9 ☐ Unknown detached g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has le 2 page performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Many er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral To the Hospital or Attending Natural 5 Pending work? 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital STO

> State Registrar

29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1205

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Medical July 28, 3:15pm Edwin D. Rest 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville Social Security Number Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** Country) Illinois May 25. 1 X M 2 - F Months Days Hours 335-14-8658 Director 87 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20815 8040 Ellingson Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: WWII Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Products Salesman 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Genser Morris Rest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8040 Ellingson Drive, Chevy Chase, Maryland 20815 Carol Rest-Mincberg - Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State Donation 5 Other (Specify) Waldheim Cemetery 07/31/2011 Forest Park, Illinois Signalure of Funeral Service Linensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M00709 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mentia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to for as a consequence of cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burileton that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20#1 Fuzh nio D006 4871 7-28-11

State

Registrar

Montrose

Rd

Rockville,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121

32. Registrar's Signature

Fazli

29 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For Amend#5 per FH State Registrar 8/1/2011 AACO HEALTH DEPT. CMH Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5218 PM Juli 2011 lam Medical Examiner 4c. County of Deat surnie Battimore len thre trunde 8. Date of Birth (Month, Day, Nov 30 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Hours -22-0416 84 Director 1926 Pennsylvania Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral USA 600 McKinsey Park Drive Unit 302 21146 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? WW II 1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Shipping Maritime 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ William P. Reilly Margaret Kelly .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Avalon Way Peachtree City, GA 30269 William Reilly, III / Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Baltimore, MD Metro Crematory, 2011 INC. 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, 21. Signature of Juneral Sep P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsis Ph sician/ Medical resulting in death) Due t (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ncer colored 24a. Was an has autopsy performed No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 110 မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 1/x f person who completed cause of death (Item 23a) (Type, Print) 301 31. Date filed (Month, Day, egistrar's Signature State JUL 2 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maurice Herbert Rindskopf Physician/ 27 Day July 2011 10:14 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis 4c. County of Death Examiner The Arbor at Baywoods Anne Arundel 8. Date of Birth (Month, Day, Year Sept. 27, 5. Social Security Numbe 081–32–3189 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 1**3€**3€M 2 □ F 93 New York **Director** Usual Residence of Decedent show 10b. County 10d. Inside City Limits ms 23a or 28a-f shorms must be notified at 10a State 10c. City. Town or Location Director Anne Arundel Annapolis Maryland 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21403 Funeral 7101 Bay Front Drive, #324 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. ö 1 Never Married 2 Married ş altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after White If Yes, Give Year or Dates 1938-72 1 Yes 2 No Specify: 'natural", 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Admiral other traumatic event, Be 17. Father's Name (First, Middle, Last) Herbert Abraham Rindskopf 18. Mother's Name (First, Middle, Maiden Surname) Amy Valentine Baumgarten 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Brookside Place Winchester, MA 01890 19a. Informant's Name/Relationship (Type, Print)
Amy Rindskopf/granddaughter Department of Health a Important: If item 27 is any injury or other trat 9 Brookside Place 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 7/28/2011 Baltimore, Maryland Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 47 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

3 XEGY Immediate Cause (Final Carcinoma Ph. si ian/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after upage...
To the Funeral Director. After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ap 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) gr!

DHMH 17 Rev 7/2009

State

Registrar

B1. Date filed (Month, Day,

8

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jul 23 2011 12:30 AM Ritchev <u>Mariorie</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Devlin Manor Nursing Home Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth Funeral (Month, Day, Yes Sep 17, 1 □ M 2 □ ₹ Director 216-30-1985 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 10301 Christie Road NE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Completed 3 XVidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hazel (unknown) **Howard Brandt** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21545 Cynthia Holler Daughter 12911 New Row Road Mt. Savage 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8/1/2011 MD Restlawn Memorial Gardens LaVale 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on pach ling. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed performed the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' 1 Yes Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Division Acciden
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pe D0033280 30. Name and address of persochwho completed cause of death (Item 23a) (Type, Print) 625 KENT AVE. STE 101 CLYNUSEIZLAND MD 21502 GUPTA 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25870 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 ROMALD EVANS ROBINSON 2:10 August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1802 Marcher Court Street Harford Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ountry) laryland 1 X M 2 - F Months Days Min Director 212-40-8264 70 Usual Residence of Decedent should be filed within a sound Mental Hygiene.

7 is marked other than "natural", or items 23a or see.

7 is marked other than "batural", or items 23a or see. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 Yes 2 XNo Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1802 Marcher Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Armed Forces?

1 A Yes 2 No Black, White, etc. T þ 1 Never Married 2 Married fimore, Maryland 21215-0036 2 No If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Specify: Completed 196 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Installation 0 Manager Paramutual Betting Be injury or other traumatic event, 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Paul Thomas Robinson Doris Gertrude Schleicher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is, any injury or other. Janice Robinson (Wife 1802 Marcher Court Street, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug Date 1 D Burial 2 ី Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Hampstead. Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home. P.A. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a consquence of for use as the burial-transi that initiated events Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? 1 Yes 2 No Yes **Division of Vital** director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 2 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Yes within 24 hours after death. To the Funeral Director: A Accident completed filled in by the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner To the best of my knowled 29b. Signature and 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) 2300 JUNES 31. Date filed (Month, Day, Year) State Registrar

2:10am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 26. 1:53 am Carol Ann Strauss 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country) Ohio **Funeral** (Month, Day, Year) 08/19/1948 1 M 2 X F 62 Director 215-48-0584 Usual Residence of Decedent 28a-f show 10a. State 10d Inside City Limits 10b County 10c, City, Town or Location within 72 hours after death with the Maryland Director must be notified 1 X Yes 2 No DC Washington 0 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a U.S.A. 1725 New Hampshire Avenue, #502 20009 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White etc. þ 1 X Never Married 2 Married "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) ibrary of Congress Librarian 5+ Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Martha L. Hildesheimer Edwin Strauss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney F. Strauss - Brother 8609 Cold Springs Road, Raleigh, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Grdns: 07/28/2011 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician Medical disease or condition resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on. that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 Yes 2 No within 24 hours after death.

Jo the Funeral Director: After this certifics completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 2 No 1 \(\text{Yes} ٩ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 70 31. Date filed (Month, Day, Year) State JUL 29 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 25872 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMbl 19:08 IETRO July 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death baltimore JOHNS HOPKINS Hospita ocial Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 27, 1938 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Country) Italy 1 □XM 2 □ F Days Hours Yrs 73 None 10d. Inside City Limits Yes 2□No 10g. Citizen of What Country? 20008 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Specify:White Specify 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ambassador of the Holy See Vatican Diplomacy 18. Mother's Name (First, Middle, Maiden Surname) Ida Bertozzi 19a. Informant's Name/Relationship (Type. Print) — Councilor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3339 Massachusetts Avenue, NW, Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sogliano Al Rubicone
Cemetery Date 20c. Location - City or Town, State Sogliano Al Rubicone, July 30, 2011 Forli Cesena, Italy 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Francis J. Collins Funeral H
500 University Blvd., W., Sil

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 X No 1 ☐ Yes 2 □ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RESOOO 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

0

State

Registrar

Margaret

31. Date filed (Month, Day, Year)

29 2011

Physician

/Medical

Examiner

Funeral

MD

Hayes

600 N. Wolfe St, Baltmore MD 21287

11-05545

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

seorge vv. Sm	ullei	1- For State Registrar	tate of Maryland	•	artment o <i>rtificate o</i>		na Mentai	, ,	Reg. No. 201	1 25873
Physic Madical Exam	ian/	Decedent's Name (First, Mide						2. Date of Dea Month	ath Day Year	3. Time of Death
Padical Exam	iner	George 4a. Facility Name (if not instituti	Washing	gton		Smullen 4b. City, Town, o	r Location of De	July 25, 2		1053 hrs
		30453 Canon Drive	on, groots and manage			Salisbury	. 2004.1017 07 20	441	Wicomico	541
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. Ia	ast birthday)	If Under 1 Yes			irth(MM/DD/YYYY) 9.	Birthplace (State or reign
Director		215-26-2601	1XM 2 F	83	Yrs	Months Day	ys Hours A	1 3-3-	1928	Country)Virginia
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Local	tion				10d. Inside City Limits
.		MD W	licomico		Salisb	11237				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	TCOMICO		Dailso	10f. Zip Code		1	10g. Citizen of What (Country?
ı with the Maryland ms 23a nr 28a-f sbo be notified at once.	_	30453 Cannon D				2180			USA	
ath wi	Funera	11. Marital Status 1 Never Married 2 X M	12. Was Deceder Armed Force:	s?		as Decedent of Hi /es, specify Cuba		Specify Yes or No rto Rican, etc.)	o- 14. Race - Ar White, et	merican Indian, Black, c.
ifter de	by Fu	3 Widowed 4 Di	1 Yes vorced if Yes, Give Yeer or Dates:	2 X No	1	Yes 2 X No	specify:		Specify:	White
D 21215-0036 should be filed within 72 hours after death with the Maryland and Montal Hygene, "mattural", or items 23a nr 28a-f sho 'is marked other than "mattural", or items 23a nr 28a-f sho artic event, the Medical Examiner must be notified at once		15. Decedent's Education (Spe	ecify only highest grade co		16a. Deceder	nt's Usual Occupa	ation (Give kind o	of work done	16b. Kind of Busine	ss/Industry
0036 within 72 piene.	ompleted	Elementary/Secondary (0-12)	College (1-4 o	or 5+)				,		
21215-0036 uld be filed within ? Mental Hygiene. marked nther than c event, the Medical	Сош	6 17. Father's Name (First, Middle	, Last)		Resea	arch Far		me (First, Middle,	State of Maiden Surname)	Maryland
21215 uld be file Mental H marked	Be (Alonzo		Smu1			Mellis			Davis
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental iant: Witen 27 is marked or other traumatic event,	To	19a. Informant's Name/Relations			T .				mber, City or Town, S	
e, M and 2 fealth item 2 traun		Holly Smith - 20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of ce	Drive, S	Salisbury Date	y , <u>Marylan</u> 20c. Location - City	d 21804 or Town, State
MOF Pages 1 ent of F		1 XBurial 2 Cremation 4 Donation 5 Other S			rematory or ot		. 01 7	20 2011	** 1	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		21. Signature of Funeral Service			22. N	Vame and Addres			Hebron, uneral HOm	
	k k	23a. Part I. Enter the disease, or	telly X	ape	70	05 E. Ma				
Physician /Medical		failure. List only one cause	op each line.							Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hyperten: Due to (or as a con:			crerotic	Cardio	vascular	Disease	Deadl
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	miner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	due to (or es a con	SELUMNCE UE	r					
ted nsit	Exar	events resulting in death) Last	Due to (or as a con:	sequence of):					
Division of Vital Records, P.O. Box 68760, To the Hospital ar Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The fer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED	d. AMENDED 23	a,27,p	er me, g	918 8–1	5-11 sm			
760, cate be ex physician he burial	Med	IF FEMALE:	23c. If yes, outco	ome of pregn	nancy				23d. Date of deli	very
Box 6876 death certificat the attending phed for use as the	cian	23b. Was decedent pregnant in the past 12 months?	LIVE DITUI	at time of dea	-4-	tal death 3	Ectopic preg	nancy	Month	Day Year
Box e death the atte	Physician/I	1 Yes 2 No 9 Un	known 9 Unknown		5 Oti	her (Specify)	-			
i, P.O. ires that the signed by be detach	by P	Part II. Other significant condit	tions contributing to dea	ath but not re	sulting in the u	inoerlying cause (given in Part I.			to the cause of death? Probably 4 Unknown
ds, I								24a. Was		autopsy findings available
COL	Completed			-				autop perfo	osy prior rmed? death	to completion of cause of ?
tal Recian: The certificate		25. Was case referred to medica	1			26 Place	of Death (Chec	1 Yes	2 No 1	Yes 2 No
Vita ysicis this cer	To Be	examiner? 1 Yes 2 No	Hospitali -	ient 2	ER/Outpatient		Othor		Residence 6 🗸 Ot	her: Scene
ing Pt After After funeral		27. Manner of Death	28a. Date of Inj (Month, Day,	jury (Year)	28b. Time of Ir		ry at Work?	28d. Describe	how injury occurred	
Sior Attend death ectur: by the	catic	⊨ 5 □ Pend	stigation	Initiana Akhar			Yes 2 No	1001		
Divi pital nr. ours after ceral Dir filled in	Certification		Id not be (Specify)	injury - At no	me, rarm, stree	et, factory, office b	outlaing, etc.	or Town, S		Rural Route Number, City
Division To the Hospital nr Attenwithin 24 hours after death To the Funeral Director:		29a Certifier	hysician: To the best of n	my knowledg	e, death occur	red at the time, da	ate and place, ar	nd due to the caus	se(s) and manner as s	tated.
To the Ho within 24 h To the Fun completely	Medical	one) 2 Medical Exa	miner: On the basis of exa and manner stated		nd/or investigat	ion, in my opinion	, death occurred	at the time, date	and place, and due to	the cause(s)
	Σ	29b. Signature and title of certified	ar .			29c. Licens			29d. Date signed (Month, Day, Year)
		30. Name and address of person	who completed cause of	death (Itom 1	23a)	O.C.I			July 26, 2011	
			int Medical Examine			e Street, Balt	imore, MD 2	1223		
Si Regis		31. Date filed (Month, Day, Year)	32. registra	ar's Signatur	8 6-	ie				

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink Fisure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jul 18 Physician/ 2011 8:30 AM Paul Smith Glenn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll Transitions Health Care 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD Months Hours Min. May 19, Days 1937 Director 220-38-0536 74 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director MD Carroll Sykesville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21784 USA 7309 2nd Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Examiner Armed Forces? Black, White, etc. 6 Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: "natural", white 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Tri-State Janitorial Service Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental cant: If item 27 is marked or မ Alberta Johnson Robert G. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 33 Weber Street Cumberland MD 21502 Graydon Smith brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Pleasant Grove Cemetery 1 X Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or 7/20/2011 MD Cumberland 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hei disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, the Hospital or Attending Physician; The law requires that the death certificate be executed 40 and the burial-tran Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1, Sor de 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2XXNo မ 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 atural 5 Pending iniury Accident Investigation To the Funeral Director completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Me

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 12-40 pm MINI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Montgomen Montgonery HOSPILON Olner Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Jan. 30, Year 1913 Country) 215-44-5172 98 Director NH Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Montgomery 01ney with the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 18001 Archwood Way 20832 **USA** within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 Specify.White 1 ☐ Yes 2 K No Specify. If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic ever Arthur Toompas Sophia Billas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Foteni T. Tiffany/Daughter 18001 ARchwood Way, Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 201<u>1</u> Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, MD . Sign at re of Juneral Servi & Licensee Francis J. Collins Funeral Home Inc. Ackard L Sales 500 University Blvd. W., Silver Spring, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, muti lobar Medical resulting in death) Due to (or as a consequence of) Examiner squantially list our ditions Examine Due to (or as a consequence if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed al-transi that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Year Pregnant at time of death Month Day Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed Yes 2 2 🗌 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: Certificate: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of : After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No s after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Hospital Medical 1. **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 972637

Registrar
DHMH 17 Rev 7/2009

State

18101 Prince Philip Drive, OLney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29 2011

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		artment of H		Mental Hy	giene Reg. N.2 (25876
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	Jeaur	2. Date of D		<i>/</i> 1 1	3. Time of Death
	Physicia Medic		Micheline Toumayan				July	25 ^{Day} 20)11 ^{Year}	4:18 A M
	Examin		4a. Facility Name (if not institution, give street and number) 6309 Newburn Dr.		4b. City, Town, or Bethes	r Location of Deat	h	4c. Cou Mont	nty of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs		rth	9. Bi	rthplace (State or Foreign
	Director		225-50-7510 1 DM 2 F 83	Yrs.	Months Days	Hours Min.	oct. 1	5,1927	Fre	ench Congo
	nd how at	ŗ	Usual Residence of Decedent 10a. State 10b. County 10c. City.	, Town or Loc	cation					10d. Inside City Limits
	faryla 3a-f s tified	Funeral Director	Maryland Montgomery Be	ethesd	a					1 🕱 Yes 2 □ No
	the N or 24	Dir	10e. Street and Number		10f. Zip Code			10g. Citizen	of What C	ountry?
	s 23a	nera	6309 Newburn Drive			20810			S.A.	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of H FYes, specify Cuba		pecify Yes or No to Rican, etc.)	- 14. F E Spec	Black, Whit	erican Indian, te, etc. hite
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Baltimore, Maryland 21215-0036	permit. Departn Importa any inju		21. Signature of Funeral Service Licenspe MO1145	22	. Name and Addres	ss of Facility I	DeVol Fu			DC 20007
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Ζ̈́	hysici nis cel I direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 F	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 Nursing I	lome 5 🖺 Res	idence 6 🗆 C	ther (Spe	cify)
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director, Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriatings to applicate the funeral director.		27. Manner of Death 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural 1 Natural Na	28b. Time of injury	28c. Injun work M 1 🗆		28d. Describe	how injury occ	urred	
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	± ₹ ₽ 8 <i>3</i>		Figure 296. Signature and title of certifier Hiller C Frieman	1	DC17			July 2		
			30. Name and address of person who completed cause of death (Item Helene C. Freeman, MD 4910 Mass	23a) (Type, P	,	2 Washin	oton. D	.C. 200	16	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and ertificate of Death		iene 201	1 25877
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3, Time of Death
	Physicia Medic		Daniel R. Vipperman Jr.		Month 07	28 20	11 6:43 PM
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of i	Death
*	<u> </u>		Union Hospital	E1kton	Lan. (Dir.	Cecil	D. II. D. A. G. A.
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs Months Days Hours Min		Year) 9	Birthplace (State or Foreign Country) MD
			216-32-3296 76 Yrs. Usual Residence of Decedent		12/19/	1754	IID
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	r dea or iter niner		Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)		American Indian, White, etc.
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Baltimore,	permit. Page 1 a Department of H Important: If its any injury or ot		21. Signature of Funeral Service Lensee	22. Name and Address of Facility	RT Foard	Funera1	Home, PA
n —			Louis 4 trom to	259 East Main St	reet, Elk	ton, MD	21921
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one course on each line.	1		est,	Approximate Interval Between
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	To t To t		29b. Signature and title of certifier	29c. License number	_	29d. Date signed (A	
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	5+IVA		30. Name and address of person who completed cause of death (Item 23a) (Type	eet EIKton	2 2	1021	
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	Í	State Registrar			Cer	tificate of Death			Reg. No.2	011	25878
Physicia		1. Decedent's Name (First, Middle, Sandra Lynn Vai	,					2. Date of Dea	25°,	2 0 °1°1	3. Time of Death 12:58 P.M
Medic Examin		4a. Facility Name (if not institution, g		nber)		4b. City, Town, or Location	of Death			unty of Death	
		90 Waverly Dr. A				Frederick				ederick	
Funeral Director		5. Social Security Number 219–86–9993 Usual Residence of Decedent	5. Sex 1 ☐ M 2 🌁 F	7. Age (In yrs. Ia	Yrs.	If Under 1 Year If Under Months Days Hours	Min.	8. Date of Birt 05/29/		9. Birthp Coun	place (State or Foreign try)MD
show	tor	10a. State 10b. County	·	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
Maryi 28a-f otifie	Director	MD Freder	ick	Fred	lerick						1 🛚 Yes 2 🗆 No
permit. Fage I and 2 should be lined within 7.2 hours aret death with the Maryland Department of Health Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 90 Waverly Dr.,	Apt. II	116		10f. Zip Code 21702			10g. Citizer	n of What Cour	ntry?
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and 2 Health tem 27 other tr		B. Suzan Vail/m 20a. Method of Disposition		20b. P		Crossover Ct.		derick		tion - City or To	own. State
Page 1 nent of ant: If i		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		State C	emetery, cren	natory or other place)		2011		erick,	
permit. Departr Importa any inju		21. Signature of Funeral Service Lic	censee /	~	22	. Name and Address of Facilit	ty Sta	uffer			
	П	23a. Part 1. Enter the diseas , or c shock, or heart failu ist on	omplications that only one cause on ea	caused the death							Approximate Interval Between
hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a _ A^		2516	nutic CIA			LVM	1 CAK	Onset and Death
Examiner	Į.	Sequentially list conditions,	D	LUON		CIUNSTE	De	De+	DEL	15	5411
d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to	or as a consequ		14051713					5411
cian an		resulting in death) Last	Due to	or as a consequ					-		
physici ts the bu	ledic		d								
been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No	1 Live	nant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
signed by the bedetached	by Phy	9 ☐ Unknown Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying cause given in Part	l.	23e. Did to	bacco use	contribute to the	ne cause of death?
en sign	ted b	- Elfno	ML O'	PISID	US	<u> </u>		1 🗆	Yes 2 🗆 I	No 3 🗆 Pro	bably 4 Unknown
ite has be	Completed				-			24a. Was autop perfo			psy findings available mpletion of cause of
ertifica ector, p	Be	25. Was case referred to medical examiner?	Hamital			26. Place of Dea	ath <i>(Check</i>		Z jest NO		2.45.10
this c	2	1 ☐ Yes 2 🗡 No 27. Manner of Death	Hospital: 1	Inpatient 2 of injury	ER/Outpatier	ot 3 DOA Other: 4 No		me 5 Resid)
r death. ctor: After by the fune	Certificate:	1 Natural 5 Pending 2 Accident Investiga	(Mon	th, Day, Year)	injury	work? M 1 Yes 2		zod. Describe II	OW HIJUTY OC	curred	
rs after de al Directo ed in by t		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place	of Injury - At ho ng, etc. <i>(Specify</i>		eet, factory, office	1	28f. Location (S City or Tow		umber or Rurai	Route Number,
within 24 hours after death. To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should	Medical	(Check 2 ☐ Medical Ex- only one) 3 ☐ Certifying	aminer: On the has	is of examination	and/or invest	occured at the time, date and igation, in my opinion, death or leath occurred at the time, date	ccurred at	the time, date a	nd place, an	d due to the ca	use(s) and manner stated.
70 To 1		29b. Signature and title of certiler	AL)			29c. License number	12		7/2	igned (Month, 27/2	011
2		30. Name and address of person wi	no completed caus	e of death (Item	23a) (Type, F	mari lono	cul	e 140	Fno	E DENI	in mg ns2
		40-10 . 1- 1- 51			2 Fr C /					1	- v

State Registrar 30. Na... 31. Date filed (Month Pay.)

Registrar
DHMH 17 Rev 1/2001

State

15245 Shady Grove Road, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

Nkiru Ezeani,

31. Date filed (Month, Day, Year)

R151747

July 27, 2011

				For State Registrar	State of	f Maryland	-	artment of F <i>tificate of E</i>	lealth and M Death	-	giene Reg. N	2011	25880
		Physicia Medic		1. Decedent's Name (First, Middle, La Kathleen	ist)	Walt	er			2. Date of De		ay 2011 Year	3. Time of Death 1355 M
•		Examir		4a. Facility Name (if not institution, giv Suburban Host		per)			Location of Death			c. County of Dea	
		Funeral Director		5. Social Security Number 214-52-2776	Sex 1 □ M 2 🕇 F	7. Age (In yrs las 63	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 4 1/12/15 1/14	th 14 9 44	8 9. Bi	rthplace (State or Foreigr
		faryland Ba-f show tified at	ector	Usual Residence of Decedent 10a. State	omery		Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
		with the N 23a or 28 ist be not	Funeral Director	10e. Street and Number 12939 Twinbro	ook Par	kway	-	10f. Zip Code 208	51		10g. C	itizen of What C	ountry?
	9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dat		_ I _	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi	
	1215-0	thin 72 hou sne, than "natu ne Medica	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)	Education rade completed) College (1-	4 or 5+)	(Give I	lent's Usual Occupa kind of work done do NOT use retired) anager	ation luring most of workir	ng		Kind of Business	anagement
pm	Baltimore, Maryland 21215-0036	l be filed wi lental Hygic rked other iic event, tl	To Be	17. Father's Name (First, Middle, Last, Julius Atchis					18. Mother's Name Kathle	(First, Middle,	Maider bet	n Surname)	-
	, Mary	id 2 should salth and M n 27 is mai er traumat		19a. Informant's Name/Relationship (Son ton/			and Number or Rura brook Pa				ip Code) Le,Md 2085
1354	imore	Page 1 arment of He lant; If iten		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		State 20b. Pla	ace of Dispo metery, cren te of	sition (Name of patory or other plac Heaven	7/29)ate /2011		Location - City o	r Town, State Spring, Md
	Balt	permit Depart Import any inj		21. Signature 15 feral Service Licer	rund	7	2 <u>2</u> 2	Name of Poddress	®.RTWALD umbia B	I FUNE lvd.Si	ERAI 1ve	SERVI er Spri	CE,P.A. ing,Md2091
7/24/11		Physician/ Medical Examiner		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Chr	ch line. Onic o	bstru	ctive p	g, such as cardiac o			9	Approximate Interval Between Onset and Death
LEEN	09	cate be executed physician and sthe burial transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (c	or as a conseque	ence of):	ailure					
たせい	. Box 687	ath certifi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ★No 9 □ Unknown		Birth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	elivery Day Year
	s, P.O	requires that the de been signed by the should be detached	2	Part II. Other significant conditions	contributing to de	ath but not resu	Iting in the u	nderlying cause giv	en in Part I.				o the cause of death?
WALTER	Division of Vital Records,	The law requirate has been page 2 shoul	Completed							24a. Was auto perfo	psv	prior to	utopsy findings available completion of cause of
3	Vital	Physician: The la r this certificate ha ral director, page ?	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆 E	R/Outpatien	1 +	ace of Death (Checker: 4 Nursing Ho		dence	6 ☐ Other (Spe	cify)
	sion of	I or Attending PP after death. Director: After th I in by the funeral	Certificate:	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 280 Place	n, Day, Year)	28b. Time of injury	28c. Injury work M 1 □	Yes 2 □ No	28d. Describe I			ural Route Number,
	Divi	pital or / ours after eral Dire			buildin	g, etc. (Specify)			, date and place, and	City or Tov	vn, Stat	e)	
		To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Exar	niner: On the basi	s of examination	and/or invest	igation, in my opinic leath occurred at the	on, death occurred at e time, date and place	the time, date a	and plac ne cause	e, and due to the (s) and manner a	cause(s) and manner stat s stated.
•		F 3 F 8		> Sizett	Li .			^ "	8637		Jı	ate signed (Monula) 24	,2011
				30. Name and address of person who Siddharth Bet			-		getown R	oad Be	ethe	esda,Mo	đ.
		Sta Registr		31. Date filed (Month, Day, Year)	Sense Sense	gistrar's Signatu	par	J .					

11-05884 James Joseph V	Vale.		or Print in Blace e of Maryland / [_	
James Joseph V	j	I- For State Registrar		•	of Death	id iviental i		201 Reg. No.	2588
Physicia		1. Decedent's Name (First, Middle,L	ast)			. <u></u>	2. Date of De Month	Dav Year	3. Time of Death
Medical Exami	ner	James Joseph Wa			Ab City Town	or Location of Dea	August 5	, 2011 4c. County of Death	2015 hrs
) ~		Anne Arundel Medical C			Annapolis	or Location of Dea	iu i	Anne Arundel	
Funeral Director			Sex 7. Age (I	In yrs. last birthda 55	y) If Under 1 Ye Months Da		Irs. 8. Date of B	irth(MM/DD/YYYY) 9. Bir L 23, 1956 Co	hplace (State or n untry) MD
	ŀ	Usual Residence of Decedent					. 1 .		
v any		10a. State 10b. County	10	c. City, Town or I	ocation			-	10d. Inside City Limits
land f shov pnce.	ō		runde1	Lothian					1 Yes 2 X No
Mary r 28a-	Director	10e. Street and Number	- 4		10f. Zip Code			10g. Citizen of What Cour	ntry?
th the		82 Old Solomons			20711			USA	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	 11. Marital Status 1 Never Married 2 X Marrie 	12. Was Decedent Evented Armed Forces?	ver in U.S. 13	 Was Decedent of H If Yes, specify Cuba 			o- 14. Race - Ameri White, etc.	can Indian, Black,
Baltimore, MD 21215-0036 germit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			1 Yes 2 A ed If Yes, Give Year or Dates:		1 Yes 2 X N	lo specify:		Specify: Wh	ite
ours a	g b	15. Decedent's Education (Specify	only highest grade comple		edent's Usual Occup			16b. Kind of Business/I	ndustry
16 n 72 h tan "n ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			ie. DO NOT use i	eliied)	D - C'	
OO3	Ē	12 17. Father's Name (First, Middle, La	et)	Roo	ofer	18 Mother's Na	ne (First Middle	Roofing Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Joseph Walsh	0.,				Fowler	maraon oarramo,	
213 buld b I Ment		19a. Informant's Name/Relationship	(Type, Print)	19b. N	lailing Address (Str			mber, City or Town, State	, Zip Code)
MD d 2 sho lth and a 27 is	- 1	Marcia Walsh /	Wife				ınd Rd.,	Lothian, MD	
Baltimore, MD semi: Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from State		isposition (Name of coor other place)	cemetery,	Date	20c. Location - City or	Town, State
Page Page ment of or oth		4 Donation 5 Other Spec		Kalas (Crematory		8/2011	Edgewater	
3alt ermit. Separti mport njury		21. Signature of Fundral Service Lic	ensee				-	kalas Funer	
	-1	23a. Patt I. Enter the disease, or co	mplications that caused the	e death. Do not e				., Edgewater	Approximate Interval
Physician /Medical		failure. List only one cause on	each line.					rest, street, or rest	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Anaphylaxi Due to (or as a consequ		probable	Deestin	ъ В		-
		Sequentially list conditions,	b						
	Ē.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	uence of):					
sit	xaminer	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
			d. AMENDED 23a, 2	7 20a_F	DOT TO G	27 11 - 7-	-II em		
O, be ex sician	eg Sign	X UNPENDED			, per me, g	/21 11 /	11 311		
876 tificat ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy	Fetal death 3	Ectopic preg	nancy	23d. Date of delivery Month	/ Day Year
Box 68760, e death certificate be execute the attending physician and ed for use as the burial - tran	Sici	past 12 months? 1 Yes 2 No 9 Unknot	4 Pregnant at tin		Other (Specify)				
D.O. BC that the des ned by the a	Phy	Part II. Other significant condition	9 Unknown	ut not resulting in	the underlying cause	a given in Part I	23e Did	tobacco use contribute to	the cause of death?
8 50 Q	٥		33111131113113	at the tracking in	and driverying deduct	giron in runti.			pably 4 🗸 Unknown
rds requi	lete						24a. Was		topsy findings available completion of cause of
Recol	Completed							ormed? death?	
Vital Rec ysician: The l his certificate l director, page	ωl	25. Was case referred to medical examiner?			26.Pla	ce of Death (Che	ck only one)		
of Vital Recing Physician: The After this certificate Uneral director, pagg	P P	1 ✓ Yes 2 No	Hospital: 1 Inpatient				sing Home 5	Residence 6 Othe	r.
n of ding Ph		27. Manner of Death 1 Natural 5 Pandia	28a. Date of Injury (Month, Day,Year	28b. Tim		ijury at Work?		how injury occurred t sustained	heesting
ivisior I or Attenc after death Director:	cati	2 X Accident Investig	ation Id 6-3-1		911 hrs 1 street, factory, office	Yes 2 X No			
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si rely filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could r	ot be	yard o		s ballaling, etc.	or Town,	(Street and Number or Ru State) 82 01d Southian, Md.	Lomons Island
Hospital 24 hours Funeral	2	29a Certifier	sician: To the best of my k			date and place, a			ed.
To the How within 24 h	edical		ner:On the basis of examinand manner stated.	netion and/or inve	stigation, in my opini	on, death occurre	d at the time, dat	e and place, and due to th	e cause(s)

30. Name and address of person who completed gause of death (item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) AUG 09 2011 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

August 6, 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or										•	ible.		
		For State Registrar		State	of Ma	arylan		•	ent of F ate of D		and N	/lental H	ygien Reg. N	28		258	82
Dharisis		Decedent's Name	e (First, Middle	e, Last)								2. Date of D	eath	Day	Year	3. Time of	Death
Physicia Medic	cal	Helen	and inatituition	n, give street and nur	hirk	ζ			ourex	1	- CD th	Augus	t (5 20	011_	6:30	A ^M
Examin	ier	,		or Living	nber)				City, Town, or Hagers		of Death		4	tc. County Wash:		on	
Funeral		5. Social Security No	umber	6. Sex 1 ☐ M 2 X F	_		ast birthda Yrs	ay) If U	nder 1 Year	If Unde	r 24 Hrs. Min.	8. Date of B	irth ay Year,		9. Birth	place (State or	r Foreign
Director		215-18-2 Usual Residence of				97	113	·.			<u> </u>	Oct.	15,	1913	Mar	yland	
ryland -f shoried at	ctor	10a. State	10b. County			10c. City	y, Town or	Location								10d. Inside Cit 1 ሺ Yes	,
he Ma or 28a e notif	Director	MD 10e. Street and Nun		ngton		Ha	gersi		. Zip Code				10g. (Citizen of W	/hat Cou		2 L NO
ıs 23a nust b	Funeral	1090 Ka	sinof	Ave.					21742					U.	S.A.		_
r death or item oiner n	by Fu	11. Marital Status 1 Never Marri	ied 2 □ Mar	12. Was Dec Armed Fo 1 \(\sum \) Yes	orces?		3. 1	13. Was De If Yes, s	ecedent of Hi specify Cuba	spanic Oi n, Mexica	rigin? (Spe in, Puerto	ecify Yes or No Rican, etc.))-		- Americ k, White,	can Indian, etc.	
2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	ed b	3 X Widowed		If You Gi	ve -	NO		1 □ Y€	es 2X No	Specify	<i>/</i> :			Specify:	Whi	te	
72 hou n "natu fedica	Completed		cify only high	nt's Education est grade completed)		(G	ive kind of	Jsual Occupa work done d use retired)	ation luring mo	st of work	ing	16b.	Kind of Bu	siness In	dustry	
within giene. er tha		Elementary/Seco	onday (0-12)	College (*	I-4 or 5	+)			rative	Ass	ista	nt	US	Gove	rnme	nt	
e filed ntal Hy ed oth event	To Be	17. Father's Name (F		Í								e (First, Middl H. Ras		n Surname)		
nould b	ľ	19a. Informant's Na					19b. M	lailing Add	ress (Street a			n • Ras		or Town, Si	ate. Zip	Code)	
nd 2 sh ealth a m 27 is ier trai		Edna S. S		Sister								gersto			21742		
ge 1 and tof Hi in fitter or oth			☐ Cremation	3 Removal from	State	C	emetery, o		or other plac			Date		Location -			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I be important if them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 21. Signature of Fur	 			Res	t Ha		Cemete e and Addres			2011 st Hav		gersi			
any per		> 5.h	rock	Singe				1601	Penns	y1va:		ve., H					2
Physician/		shock, or hear Immediate Cause (I disease or conditio	rt failure. List o Final	r complications that only one cause on ea	caused ach line	the death	P. R.	enter the r	node of dying	g, such as	s cardiac o	or respiratory a	arrest,			Approximate Interval Betv Onset and D	veen
Medical Examiner		resulting in death)		Due to	(or as a	consequ	ience of):	tic	₩	1	4.	5					
d Sit	Examiner	Sequentially list con if any, leading to im cause. Enter Under	nmediate rlying	b. Due to	(or as a	consequ		. (-)	•	. 011	1 10						
executed an and rial-transi	Exar	Cause (Disease or that initiated events resulting in death) L	S	c	(or as a	consequ	ence of):								\dashv		
ate be e hysicia the buri	dical			d											_		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral after death. On the Funeral afterofor, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months?	23c. If yes, ou 1 Live 4 Preg 9 Unk	Birth 2 nant at	2 🗌 Feta	death	3	pic pregnanc r (specify)	у				23d. Dat Mor			'ear
hat the ed by tl detach	y Phy	9 Unknown Part II. Other signifi		ons contributing to a	death bu	ut not resi	ulting in th	ne underly	ng cause giv	en in Par	t I.	23e. Did	tobacco	use contri	bute to t	he cause of de	eath?
requires that the de been signed by the should be detached	ted by											1 🗆	Yes :	2 🗆 No	3 🗌 Pro	bably 4	Jnknown
The law re cate has be page 2 sh	Completed												opsy formed?	P	rior to co eath?	psy findings a empletion of ca 2 No	
sician: certific irector,	o Be	25. Was case referre examiner? 1 Yes 2	_ /	Hospital:	14:	-1 0 D	ED/0: 4	**	Othe	·		only one)		. V 1		Assist	ed
ng Phy ter this neral d	te: To	27. Manner of Death		28a. Date		у	28b. Time injur		28c. Injury work	at		me 5 Res 28d. Describe) LIVI	<u> II</u> g
ttendir death. :tor: Af : the fu	Certificate:	2 ☐ Accident 3 ☐ Suicide	Investi 6 Could	gation not be				М		Yes 2		00/ 1		. (1)		/ D	
tal or A s after al Direct ed in by		4 Homicide	determ	nined build	ing, etc.	(Specify))	street, lac	itory, onice			City or To			r or mura	l Route Numbe	er,
To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 only one) 3	☐ Medical E	Physician: To the backaminer: On the backaminer: On the backaminer:	sis of ex	amination	and/or in	vestigation	, in my opinio	n, death c	ccurred at	the time, date	and place	ce, and due	to the ca	use(s) and mar	ner stated
vith		29b. Signature and t	title of certifier	me	_J				29c. License D U G		3 6		29d. D	ate signed	(Month,	Day, Year)	
		30. Name and addre			se of de	ath (Item	23a) (Typ	e, Print)	1126		Pal	et.viv		WD	1 1	740	
Stat		31. Date filed (Month	h, Day, Year)	32.	e _s etraj	r's Signat	ure	7		Ma	a ex	1 . 4	1	14 (1)	<u></u>	/	
Registra		A	UG 12	2011 /2	w	P	9. 4	Sark			•						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend if m 20b per fh e918 8-30-11 vr State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 20 25883 Certificate of Death 3. Time of Death 4:30P.M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Elnora Bullock Aug.6,201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Examiner 926 N. Bentalou Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Carolina 1 □ M 2 🔽 F Days Hours (Month, Day, Year) Months 249-72-8045 Yrs Director 1944 67 June Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No N/A Baltimore <u>Maryland</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 926 N. Bentalou Street 21216 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner han "natural", or it Medical Examine Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Speciallack 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic mental. Elementary/Seconday (0-12) College (1-4 or 5+) 11th grade <u> Wousewi</u>fe Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Bessent Zula Chestnut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type, Print) Tammy Elmore/Daughter N. Bentalou Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstewn Rd Baltimore, MD 21215 21. Signature Juneral Service Lice Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ GASTROINTESTINAL disease or condition resulting in death) MAN TH Medical **Examiner** LON LANC Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Box 68760 attending pl IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown a Unknown Division of Vital Records, P.O. þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END STAGE RENAL DISEASE To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes |요 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) he Funeral Director: After this pleted filled in by the funeral directed filled 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006586 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMMONDS FERRY RD BALTIMORE, MD 21227 2717 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G918 8/15/2011 JH State of Maryland / Department of Health and Mental Hygiene 25884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bambrick Catherine Tierney 2011 1:10A M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Laure1 8750 Susini Drive 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** March Day, Year) 1 🗆 M 2 🖫 F Months Days Hours Director 94 Yrs 217-10-6757 1917 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No MD Howard Davton 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4844 Ten Oaks Road 21036 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or þ 1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 ☐ Widowed 4 ☐ Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Patrick A. Tierney Nora Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4844 Ten Oaks Road Dayton, MD 21036 Suznne Hill (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Louis Cemetery 8/9/2011 Clarksville, MD 21. Signature of Funeral Service Liceusee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or an consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's examiner? Hospital: Certificate: To 1 🗌 Yes 2 🗔 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Thesidence 6XX Other (Specify) Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Registrar

State

29a Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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1 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00053150

29d. Date signed (Month, Day, Year)

21045

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9650 Lennes Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G918 8/15/2011 JH State of Maryland / Department of Health and Mental Hygiene 20 | | 25885 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beere James 0711 AUG Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Md. 8. Date of Birth **Funeral** Hours 217-26-1768 Director 79 1073171931 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: of the marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 Yes 2 No Md. Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7013 Carmae Rd 21784 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Appraiser Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon James Beere Elizabeth Fechter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne I. Beere (Wife) 7013 Carmae Rd. Sykesville, Md. 21784. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 08/18/2011 Sykesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition tour S Medical resulting in death) Due to a s a consequence of) Examiner mellitus Sequentially list conditions, if one leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral irrector: Atter this certificate has been signed by the attending physician and completed literal incector, page 2 should be detached for use as the burial-transit demention Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Abrillation Hypertension, atrial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 900 067322 2011

State

Registrar

Balto,MD 21287

600N. Wolfe St. Carnegie 568

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAndeep Bansal

AUG 1 5 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna Dorothy Bryant Aug. Day 2019 7:52 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Mospice Dove Mouse Carroll Westminster 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F 91 212-18-7921 Addenth, 23 Ye 1919 **Director** comaryland Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Reisterstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 236 Walgrove Rd. 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Lady Hecht Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked o any injury or other traumatic evenore. ပ George Clarence Elliott Estelle Elizabeth Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 Walgrove Rd. Reisterstown, MD. 21136 Thomas W. Bryant, Sr. - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Parkwood Cem. Aug. 1 Burial 2 Cremation 3 Removal from State 16, 2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chart Tuneral Chape F.A. ELEN ELLO 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine attending physician and for use as the burial-transit by

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 page this certificate

Be Completed by Physician/Medical ၉ Medical Certificate:

cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
resulting in death) Last	Due to (or as a conseq	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Dectop	ic pregnancy (specify)		23d. Date of de Month	llvery Day Year
Part II. Other significant conditions o	ontributing to death but not re	sulting in the underlyir	ng cause given in Part I.		tobacco use contribute to	
				per	opsy prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)		
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 \square Res	sidence 6 Other (Spec	ity) Horpice
27. Man of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No		how injury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact	ory, office		(Street and Number or Ru own, State)	ral Route Number,
(Check 2 L. Medical Exami	sician: To the best of my know iner: On the basis of examinatio se Practioner: To the best of m	n and/or investigation.	in my opinion, death occurred	at the time, date	and place, and due to the	cause(s) and manner state
29b. Signature and title of certifier	1		9c. License number		29d. Date signed (Month	

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NHO 31. Date filed (Month, Day, Year,

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	aryland		ertificate of L		na ivie		Reg. No.	011	25887
	Physicia	n/	1. Decedent's Name Gloria	_	_					2	. Date of Dea	oth 07	Year	3. Time of Death 9:28 A M
	Medic Examin			Lac not institution, gi	ve street and number)	arnes		4b. City, Town, or	Location of	Death	80		2011 ounty of Death	
					Hospital			Cheverly					nce Ge	orge's
	Funeral Director		5. Social Security Nu 577-48-36	541	Sex 1 M 2 X F 7. Agr		st birthday Yrs.	Months Days	If Under 24 Hours	Hrs. 8 Min.	. Date of Birt (Month, Day 04 01	/. Year)	Cou	nplace (State or Foreign ntry) DC
	and show	tor	Usual Residence of 10a. State	10b. County		10c. City	, Town or I	ocation						10d. Inside City Limits
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	ath wi	Funeral Director	500 N • Ha	arry S.	Truman Driv			. Was Decedent of H	spanic Origin	n? (Specifi	y Yes or No-	USA 14	. Race - Amer	ican Indian.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	1 Never Marrie		Armed Forces?			If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, F	Puèrto Ric	an, etc.)		Black, White	, etc.
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е, -	and leaf		Martin E 20a. Method of Disp	osition			ace of Dis	position (Name of		Dat			ation - City or	Town, State
m 0	Page 1 ment of I ant; If its ury or o			☐ Cremation 3 5 ☐ Other (Spe	☐ Removal from State cify)			ematory or other place Heaven		8/15	/2011	Silve	r Spri	ng, MD
Baltimore,	permit. Page 1: Department of H Important: If its any injury or of		21. Signature of Fun	neral Service Lice	engle)			22. Name and Addres						1 Home
					mplications that caused one cause on each line			nter the mode of dyin	g, such as ca					Approximate Interval Between
- 5	Pnysician/		Immediate Cause (F disease or condition	Final	- a - 1 - A	TAL	(ANSU	- /	tra	Mth.	wa	-	Onset and Death
-	Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):				(
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Box	e death the atte	ıysici	1 Yes 2 L 9 Unknown		4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath 5	Other (specify)					Month	Day Year
о. О.	that the ned by the detach	by Ph	Part II. Other signifi	icant conditions	contributing to death b	ut not resu	ulting in the	underlying cause give	/en in Part I.		23e. Did t	obacco use	e contribute to	the cause of death?
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ion	ttendii death. ttor: A: the fu	Certificate:	2 Accident 3 Suicide	Investigat	the -	ını. At ha	mo form (M 1 treet, factory, office	Yes 2 N		4 Lagation /	Street and I	Number of Pu	al Route Number,
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_	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certifical completed filled in by the funeral director,	Medical	29a. Certifier 1- (Check 2		hysician: To the best of miner: On the basis of e									ted. ause(s) and manner stated.
	o the hithin 2, the Foundation	Me		Certifying N	urse Practioner: To the				e time, date a			e cause(s) a		stated.
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend#23aperphye918 8-15-11 d.o. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. Day Physician/ Year 261 02:49 PM ALBERT SAMUEL CRAFT SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Prince George's Hospita Laurel Laure 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Days Hours Min. (Month, Day, Year 577-42-4309 Director /14/1933 GEORGIA Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director WASHINGTON 1 X Yes 2 No DC 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral UNITED STATES 901 NEW JERSEY AVE NW 20001 #411 ural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Arrived Forces?

1 Pyes 2 No
If Yes, Give 1954
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural" Completed 3 Widowed 4 □ Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE LABORER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ ALBERT CRAFT SR ARLENA CRAFT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KENNETH KEYS/SON 16009 MALCOLM DR. LAUREL. MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SURRECTION 7/18/11 21. Signature of Funeral Service Licensee CEM. CLINTON, MD 22. Name and Address of Facility CAPITOL MORTUARY MARYLAND AVE. NE WASHINGTON DC mplications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or o Approximate Interval Between shock, or heart failure. List or v one cause on each line Onset and Death Immediate Cause (Final SHOCK Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Intraabdominal Sepsis Sequentially list conditions, if any leading to impossible cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a nonsequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) detached signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Division of Vital Records, Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No 1 Yes 2 No certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital Other: 1 🗌 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 3 only one 29b. Signature and title of 29d, Date signed (Month, Day, Year) - a-2011 me and address of person who completed cause of death (Item 23a) (Type, Print Van Dusen Rd acoul 7300 MIN

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

AUG 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tem 5 per fh g922 12-13-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edna Burkhart Carpenter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll Social Security Number 2732 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Age (In yrs. last birthday) May 3, Year) 928 Months 83 Days Hours Min. Country) 1 M 2 XX 217-32-272 TNDirector Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🖵 No Carroll Sykesville Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3994 Robin Hood Way 21784 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify: "natural". Specify: Completed 3 ₩Vidowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Albert Burkhart Elizabeth Vance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12127 Buffington Road Woodsboro, MD 21798 Edna Suzette Dotterer Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If ite any injury or ot 1 N Burial 2 Cremation 3 Removal from State Woodlawn Cemetery Aug. 16,2011 Knoxville, TN 4 Donation 5 Other (Specify) neral Service Licens 22. Name and Address of Facility
Burrier-Queen Funeral Home 21. Signature & Crematory nter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of each line. MĎ 21784 Winfield Approximate 23a. Pag ck Interval Between AMYLOIDOSIS Onset and Death Imm diat Cause (Final SYSTEMIC disease of condition resulting in death) Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or certying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by INJURY KIDNEY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 2 No 25. Was case referred to medical completed filled in by the funeral director. 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After the 28c. Injury_at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number **D** 30263 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 8-11-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD 200 MEMORIAL AVENUE, WESTI UNSTER, MD ZIIS 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygien [9] For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 19:00 M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 700 W40* Bultmore Center Ralto. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, 1**基** M 2 □ F 152-22-1820 Yrs Director 84 April Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral USA 810 Powers St 21211 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status rmed Forces?

Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. US Navy 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Textbook Company Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or other traumatin ones. ည Croyder Harry G. Croyder Dorothy Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page Croyder (Daughter) 810 Powers St., BAltimore, MD 21211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State Baltrinore_crematory 8/15/11 Baltimore, Maryland 4 Donation 5 Other (Specify) Loudon Park 21. Signature of Funeral Servic 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pleural EFFU Physician/ Sior veek Medical resulting in death) Examiner cancer pecter Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans and Due to (or as a consequence of) ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ğ Day Year Pregnant at time of death Month signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an page 2 s autopsy performe has Rena diseas certificate 2 🔀 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Tyes 2 🔀 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Μ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, ss of person who completed cause of de ath (Item 23a) (Type, Print) 30. Name and addre Shik 4105 P. Warfor Greater Linny GBMC Enca 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 📗 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav a^{M} AUGUSTUS DORMAN 2011 1:44 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CO RIVERVIEW NURSING CENTER ESSEX 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 **X M** 2 □ F Country)
MARYLAND 717-10-6890 **Director** 93 1918 14 Usual Residence of Decedent show filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND BALTIMORE CO **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 U.S.A. EASTERN BLVD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: BLACK 3 Midowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4th grade JANITOR BALTO. CO SCHOOLS Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JENNIE TRIMBLE FROST DORMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores C. Myers/Niece P.O. Box 304, White Marsh, Md., 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-15-11 GARRISON FOREST OWINGS MILLS, MARYLAND 21. Signature of Fyneral Service Licensee WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. BLVD., ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner and resulting in death) Last attending physician for use as the burial Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be F FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPER TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan After this certificate has I funeral director, page 2 s autopsy performed' Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Cirector Aft completed filled in by the form 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Julka M.D.

completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	I.	State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar Certificate of Death Reg. No. 25892
		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Physicia Medi		Elizabeth Ealy Day Year 1529 M
Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
~^^		5. Social Security Number 6. Sex 7, Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 1 M 2 V F 7. Age (In yrs. last birthday) Yrs. 86 Yrs. 1 Days Hours Min. 1 D 2 7 24 9. Birthplace (State or Foreign (Month, Day, Year)) You VA
		Usual Residence of Decedent
ryland f sho	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 ☒ Yes 2 ☐ No
ne Ma or 28a notifi	Director	MD NA Baltimore 1 NA Street and Number 109. Citizen of What Country?
with the 23a c	Funeral	2737 West Fairmount Ave 21223 U.S.A.
leath items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36 after of I", or Kamir	d by	1 □ Never Married 2 □ Married 1 □ Yes 2 🗓 No If Yes, Give 1 □ Yes 2 💆 No Specify: Specify:
hours	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
215 in 721 e. nan "r	duc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) (Give kind of work done during most of working life. DO NOT use retired)
d with bygien ther the	Be C	8th grade na Gourmet Deli Dietician Kibbys Restaurant
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last) Peter Beverly 18. Mother's Name (First, Middle, Maiden Surname) Cora Beverly
lary should the and Me is mark aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, Marylan and 2 should be fil Health and Mental em 27 is marked of ther traumatic ev		Eliar Tucker-Daughter 4221 Vermont Ave, Baltiore, Md 21229
of He of He r other	1	20a. Method of Disposition 1 🔀 Burial 2 \square Cremation 3 \square Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Limor : Page 1 tment of tant: If it		4 Donation 5 Other (Specify) MD National Mem. 8/17/2011 Laurel, Md
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltiore, Md 21215
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Physician/	1	Immediate Cause (Final disease or condition a. According to the condition of the condition
Medical Examiner		Due to (or as a consequence of):
	Jer	Equantially list conditions, if any, leading to immediate Due to (or as a consequence of):
d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.
be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):
the part of the contract of th	dical	d
Ox 687 eath certifice attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant. 23c. If yes, outcome of pregnancy.
	iciar	in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)
P.O. BC that the dea	hys	9 Unknown
	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ords, F v requires th s been signe should be o	ted	NSTEMI (myocardial infaction) 1 Yes 2 No 3 Probably 4 Unknown
law r has b e 2 sh	Completed	24a. Was an autopsy findings available prior to completion of cause of death?
fital Reco sician: The law certificate has t		1 Yes 2 No 1 Yes 2 No
Vita ysicial is certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No
In of V ding Phys th. After this funeral di		27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
eath. or Aft	fica	1 Natural 5 Pending (Month, Day, Year) Injury work? 2 Accident Investigation S Usicide 6 Could not be
Division of Vital Records, tal or Attending Physician: The law requires its after death. al Director After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the within To the compl	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Battur Willia 3 MD 1871892240 08/11/11
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sta	te	31. Date filed (Month, Day, Year) AUG 15 2011 AUG 15 2011 AUG 15 2011 AUG 15 2011 AUG 15 2011 AUG 15 2011 AUG 15 2011 AUG 15 2011 AUG 15 2011
Registr	ar	AUG 15 2011 August S. Sandul

FARAC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 12, 2014 12:35 AM SALVATORE GRIMALDI 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GENESIS ELDERCARE CROMWELL CENTER PARKVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Pay Year) 6/2/1916 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, Months 1X M 2□F SICILY 95 056-26-6174 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No TOWSON BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1571 GLEN KEITH BLVD. 21286 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CO. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT SUPERVISOR 5TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BIAGGIO GRIMALDI ANTONIA PIPTONE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA GRIMALDI/WIFE 1571 GLEN KEITH BLVD. TOWSON, MD 21286 Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DULANEY VALLEY MEM 1 Burial 2 ☐ Cremation 3 ☐Removal from State 8/17/2011 COCKEYSVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD MO0217 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

timore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a consequence of):	$C_{\alpha}(\vec{\mathbf{D}})$			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	/V <i>V</i>			
_	resulting in death) Last	Due to (or as a consequence of):				
ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		topic pregnancy her (specify)		23d. Date of delive Month	ry Day Year
ed by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco	use contribute to the	
Completed				24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
e R	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	•	
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify	()
ation:	27. Manny of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how inj	jury occurred	
ertification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura ate)	l Route Number,
edical		nysician: To the best of my knowledge, death or miner: On the basis of examination and/or inves and manner stated.				
Ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month,	Day, Year)

State Registrar

31. Date filed (Month, Day,

AUG 1 5 2011

DHMH 17 Rev 1/2001

ddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25895 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 10 2011 11:20A M MILES ALAN GILDEN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthpia-Country) MD **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min 03/20/1953 Director 216-52-9297 58 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7318 PARK VILLAGE COURT 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWNER PORTERS SUPPLY COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHARLOTTE SIEGEL NORMAN GILDEN SARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7318 PARK VILLAGE COURT, BALTIMORE, MD 21208 LINDA C. KING/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ARLINGTON CEMETER CHIZUK AMUNO CONG 4 Donation 5 Other (Specify) 08/12/2011 BALTIMORE, MD Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ monas resulting in death) True to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE es, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 t perform 2 No 1 Ves

Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s been signed by the should be detached

Baltimore, Maryland 21215-0036

Completed Be ျ Certificate:

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) Hospital 1 Tyes 2 NO No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 5 Pending injury Natural 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) Name and

bookles ST

State Registrar

funeral director.

the

completed filled in by

After

24 hours after deat Funeral Director:

within 2 To the F

DHMH 17 Rev 7/2009

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per Syr G918 8/15/2011 JH State of Maryland / Department of Health and Mental Hygiene 2 C 1 1 State Registrar 25896 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Holcom DO 1139 AM Lanny 2011 Aug Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth
June 22 1944 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 🌠 M 2 🗆 F 219-40-8160 67 Director Iowa Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland thit and Mental Hyglene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8201 Northview Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1√2 Yes 2 □ No 1964-Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Divorced 4 Divorced Completed 1966 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland State Police Elementary/Seconday (0-12) College (1-4 or 5+) law enforcement officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Everett Holcombe Lavon Heathman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Chris Holcombe (son) 405 Carroll St., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 【XCremation 3 ☐ Removal from State Sykesville, MD 4 Donation 5 Other (Specify) County Cremation 8-14-11 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Para Darget A eresert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ astrointestina disease or condition Medical resulting in death) Examiner <u>pan</u>creatic Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Discrept at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica! Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 000 6651 M.D 12 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nishi Rawat 5755 Cedar Lane Columbia ,MD 21044

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1430 2011 Jerry Lee Hawkins August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) 07/06/1943 9. Birthplace (State or Foreign Country)
Md. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**3** M 2□ F 218-40-9137 68 Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show the Medical Exp. three result be notified at 1 Yes 2 No Director Carrol1 Sykesville Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21784 USA 6028 White Rock Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 □Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married ् Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be flied withir Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then eny Injury or other treumetic event. Elementary/Secondary (0-12) College (1-4or 5+) Masonry Work Masonry 12yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Chester Hawkins Kay Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy King (Daughter) P.O. Box 331 Finksburg, Md. 21048. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 08/15/2011 Sykesville, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10da Entero coccal /Medical Due to (or as a consequence of): Examiner squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 2 1 No 1 Yes 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 ₩ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No the t 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINU 291 Tunes 32. Registrar's Signature State Registra

amend #29 bat Per MEH v 69 48 186 part 29 ht of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RO PM 508914 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimosp SECOUR HOSPIRI 2000 W. BOITINOSE ST 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6 Sex 8 Date of Birth 9 Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 05-09-1945 1 🗆 M 2 🕱 F **Director** 65 212-44-4629 VA Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1X Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21215 U.S.A 3458 PARK HEIGHTS AVE. items 2 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 ☐ Yes 2 🛛 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 Widowed 4 Divorced BLACK Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SOCIAL SECURITY ADMIN CLAIMS ADMINISTRATOR 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili.
Department of Health and Mental |
Important: If item 27 is marked c
any injury or other traumatic eve ပ္ ANTIONETTE DYSON LESLIE DYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3458 PARK HEIGHTS AVE. BALTIMORE, MD 21215 KENNETH D. ANDREWS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of unk unk Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) cemetery, crematory or other place)
King Memorial Park 8/22/2011 e of Fun val Servic 22. Name and Address of Facility
WILLIAM C. BROWN C
1206 W. NORTH AVE. COMMUNITY FUNERAL HOME P.A. E. BALTIMORE, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MONT disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to juries a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death detached 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 뎯 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print) Bon School Hox 5000 31. Date filed (Month, Bay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:25 PM 0 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL GOOD SAMARITAN BALTIMORU 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 1 M 2 W F Days Hours Min. 128-26-7588 Director an "natural", or items 23a or 28a-f show Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho. 10a, State 10b. County Director 10d. Inside City Limits 1 🗌 Yes 2 🗀 🗖 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 4 or 5+) traumatic event, the Be 17. Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden ၉ ormant's Name/Relationship (Typ), Print) 19b. Mailing Address (Street and Number or Rural Route Number City permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Doenses 10155 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ PULMONARY EMBOLISM Medical Due to (or as a consequence of) Examiner CHEMI(Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires GBSTRUCTIVE PULMONARY DICEASE 1 Yes 2 No 3 Probably 4 Unknown Completed PULMONARY HUPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 1 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 W No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the I only one) 29b. Signature and title of certifier M.D. 10111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MD 21239 NANDINI YADAV 5601 LOCHRAVEN BLUD BALTIMORE State 32. Registrar's Signature Registrar

1042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month () 8 exander James Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MAIN STREET BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 03-/2-9. Birthplace (State or Foreign Country) S C 7. Age (In yrs, last birthday) **Funeral** Min. 248-22-944 1 XM 2 🗆 F 86 Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 ☐ No 10e. Street and Number ò 10g. Citizen of What Country? Funeral 23a 514 MAIN STREET 21222 USA items ? within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Specify: BLACK Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BETHLEHEM STEEL TEELWORKER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES RICE EMMA Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. ESSEX KOAD. D. HARRIS DAUGHTER BALTO. MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 18 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) VAILEY Dulaney 2. Name and Address of Facility VAUGITN GREENE FUNERAL SCV3 BAUTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown been s Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy after death.

Director: After this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident injury work?
1 Yes 5 Pending 2 No filled in by the Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowled 29b. Signatur 29d. Date signed (Month. Day, Year) 8-12-11 50071287 30. Name and address of person with dress of person who completed cause of death (Item 23a) Type, Print) Suite 4105, Baltinere, MO 670

Registrar DHMH 17 Rev 7/2009

State

Month, Day, Year)

31. Date filed

AUG

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Reuben Medical James Jones Jr. 08 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2525 Eutaw Place Apt 601 Baltimore **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours (Month, Day, Year) **Director** 231**-**44**-**4259 09 Usual Residence of Decedent 3a or 28a-f show be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Eutaw Place Apt 601 21217 U.S.A. 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give X þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Nidowed 4 Divorced Specify: Black traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Foreman <u>Insullation Co</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Reuben James Jones Sr. Mamie Dublin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 <u>Monica Jones-Daughter</u> Eutaw Place Apt 601, injury or other Baltimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) King Memorial Park 8/13/2011 Woodlawn, Md 21. Signature f Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave, Baltimore, Md . Enter the disease, or complications that cause , or heart failure. List only one cause on each lin 23a. Part shoc the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death d eno corcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 16 Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death Month Day Year been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown certificate has be irector, page 2 sl 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes 2 N 1 🗌 Yes 2 \square No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Tes Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No. Investigation Could not be hours after deat neral Director; Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANDAU Court STOWN Mn 21133

DHMH 17 Rev 7/2009

State Registrar 11-05901 John Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lohn Johnson			ate of Marylan					Menta	al Hyg	giene		201	t	0.5	
		1- For State Registrar		Cer	tificate of	Death	_		10	Re Date of Deal	g. No.	201	1	25	1117
Physicia Medical Examin		Decedent's Name (First, Middle Total			7	ohn a	on	T∽		Month	Day	Year	3	Time of Death	١
wieulcai Examin		John 4a. Facility Name (if not institutio		ander		ohns lb. City, To				August 6,		c. County of De	 ath		-
		2502 W. Coldspring A		20.7		Baltime						·			
Funeral	┪	5. Social Security Number	6. Sex 7	. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th(MM	/DD/YYYY) 9. I		lace (State or	
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	ŀ	Usual Residence of Decedent													
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th the Maryland 23a or 28a-f sho notified at once.		2502 West Co				L		1215		2 11		U.S			
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than it event, the Medica		John Alexande		n Sr.	19h Mailing	n Address		tha			nber (City or Town, St	ate. Z	'io Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Ex miner must be notified at once.	-1	Vontia Johnso			1.00							Md 20			
and 2 and 2 Fealth item 3	1	20a. Method of Disposition		20b.	Place of Dispos	ition (Nam				Date		Location - City			
DOF ages nt of] nt: If other		1 Burial 2 XCremation		m State	crematory or other on-Si			E	3/11	/2011	Ва	altimo	re	, Md	
Baltimore, permit. Pages I an Department of Hea Important: If itel	1	4 Donation 5 Other Si 21. Signature of Funeral Service			22. N	lame and A	ddress				100				
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Physician	T	23a. Part I. Enter the disease, or failure. List only one cause		used the death	. Do not enter t	he mode of	dying, s	such as ca	ardiac or i	respiratory ari	rest, sh	lock, or heart		Approximate In Between Onse	
/Medical Examiner		Immediate Cause (Final disease	_{a.} Hypertensive			iovascul	ar Dise	ease					4	Death	
-		or condition resulting in death)	Due to (or as a	consequence o	of):										
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Vita	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	npatient 2	ER/Outpatien	t 3 D	DA [Other ₄	Nursing	Home 5	Resid	dence 6 🗸 0	ther:	Scene	
ision of Vital Attending Physician: r. eath. rector: After this certif	n: T	27. Manner of Death	28a. Date of (Month,	of Injury Day,Year)	28b. Time of	Injury 2	,	y at Work		28d Describe	how in	njury occurred			
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Division To the Hospital or Attent within 24 hours after ceath To the Funeral Director: completely filled in by the	edical	(Check only Certifying F	Physician: To the best aminer:On the basis o	f examination											
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		aux.T2					O.C.N	M.E.			Αu	ıgust 7, 201	1		
		30. Name and address of perso	n who completed caus	e of death (Ite	m 23a)										
0	. (2	Ana Rubio MD. As	sistant Medical E	Examiner	900 W. Bal		treet, l	Baltimo	re, MD	21223					Į.
	ate		2011 A Re	gistrar's Signa	Law bay	1.1									
Regist	E	HOU TO	LUII LENGT	WW 10	LEGIT										

11-06018 William Knight

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

lliam Knight	State of Maryland / De	epartment of Certificate of		_	201 ag. No.	1 25903
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last) William W.	· · · · · · · · · · · · · · · · · · ·	night	2. Date of Deat Month August 10	th Day Year , 2011	3. Time of Death 1747 hrs
	4a. Facility Name (if not institution, give street and number) 1102 Druid Hill Avenue Apt. 410	41	o. City, Town, or Location of Dea Batlimore	ath	4c. County of Dea	th
Funeral Director	237-76-5731 1⊠M 2□F 6	rrs. last birthday) 4 Yrs.	If Under 1 Year If Under 24H Months Days Hours M	lin	th(MM/DD/YYYY) 9. B Fore	
5-0036 cd within 72 hours after death with the Maryland stygiene. other than "satural", or items 23a or 28a-f show any the Medical Examiner must be softlind at once. Completed by Funeral Director	Usual Residence of Decedent 10a. State	in U.S. 13. Was		Specify Yes or No-	0g. Citizen of What Co U • S • A • 14. Race - Ame White, etc.	10d. Inside City Limits 1 X Yes 2 No untry?
5-0036 State of within 72 hours after of whith 72 hours after other than "outural", of the Medical Examiner of Completed by F	Widowed 4 X Divorced of Section Year or Dates: 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na	d) 16a. Decedent' during mo	Yes 2 X No specify: s Usual Occupation (Give kind o st of working life. DO NOT use r	etired)	Specify: Bl	/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. Lact: If item 27 is marked other thas or other traumatic eveet, the Medica To Be Comple	17. Father's Name (First, Middle, Last) William Wooten 19a. Informant's Name/Relationship (Type, Print) Kantahyannee Murray-Niec	1.7	Lucill Address (Street and Number of Seton Hills		nt nber, City or Town, Stat	
Baltimore, M permit. Pages I and 2 Department of Health Importact: If item 2 iojury or other traun		Ob. Place of Disposit crematory or othe On-Sit	on (Name of cemetery, er place)	Date /13/201]	20c. Location - City of Baltimo	r Town, State
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Card Due to (or as a consequence)	liovascular Dise		or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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be executivities in and aurial - tra	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d. AMENDED 23c. If yes, outcome of p	2 Feta	il death 3 Ectopic preg	nancy	23d. Date of delive Month	ry Day Year
P.O. es that to gened by the detacl	Part II. Other significant conditions contributing to death but n Diabetes Mellitus	ot resulting in the un	derlying cause given in Part I.			the cause of death? bbably 4 Unknown
	25. Was case referred to medical		26.Place of Death (Chec	autop perfor 1 Yes :	med? death?	
_ # `~ # I ∩ I	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ER/Outpatient 28b. Time of Inj			Residence 6 Oth	er: Scene
Divious afternation of the property of the pro	3 Suicide 6 Could not be determined 28e. Place of Injury - A determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my know	vledge, death occurre	factory, office building, etc.	or Town, S	tate) e(s) and manner as sta	tural Route Number, City
	one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (i		29c. License number O.C.M.E.	d at the time, date a	and place, and due to to to 29d. Date signed (M August 11, 201	onth, Day, Year)
5 State	Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Sign	900 W. Baltin		MD 21223		
Registrar HMH 17 Rev 1/2001	AUG 1 5 2011 Janua	A. Jan.		·		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For Amend Items Registrar	State of Ma 23aPtII,2	ryland,	28a-f Cer	irtment of per me tificate of	1 H	ealth and N 1918,08/1 eath	/lental Hy . 5/2011	gien lhb Reg. N	^e 2011	25904
Physicia Medi		1. Decedent's Name (First, Middle, La Elizabeth	T.	Kin	g				2. Date of De Month ハじ こ		Day Year	3. Time of Death
Examir		4a. Facility Name (if not institution, give	e street and number)	-				Location of Death		4	c. County of Deat	h
Funeral Director		213 03 3191	ex		t birthday) Yrs.	If Under 1 Ye Months Day		If Under 24 Hrs. Hours Min.	8. Date of Bir July 7,	th ly, 199 7	9. Birt Mar	hplace (State or Foreign Tand
iryland a-f show iied at	ctor	Usual Residence of Decedent			Town or Loc							10d. Inside City Limits 1 😾 Yes 2 🗌 No
rith the Ma 23a or 28a st be notii	Funeral Director	10e. Street and Number 2822 Carroll St		Dar	CIMOI	10f. Zip Cod	le 123	30			Citizen of What Co	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒N. If Yes, Give Year or Dates.		- 1	1	of Hisp uban,	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
Baltimore, Maryland 21215-0036 oemit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam.	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 12	Education rade completed) College (1-4 or 5+)		(Give k	NOT use retire	ne dui ed)	iring most of work	ing	16b.	Kind of Business	Industry
Id 2 lled wi I Hygie other rent, ti	Be	17. Father's Name (First, Middle, Last)			тете	phone 0	$\overline{}$	18. Mother's Nam	e (First, Middle,	Maidei		
Vland be find	₽	Harry		King			\perp	Margar	et M	ary	Gar	vey
d 2 should alth and 1 straums r traums		19a. Informant's Name/Relationship (1) Carol A. McCoy	Type, Print) (Niece)					nd Number or Rura Ave., Ba			or Town, State, Zip D 21230	Code)
imore Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	cer	netery, crem Cathe		ne 1	tery 8/1		Bal	Location - City or timore, l	Maryland
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licen	86								Funeral l e, MD 21:	
Priysician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.					such as cardiac		rest,		Approximate Interval Between Onset and Death
) Medical Examiner	je.	Sequentially list conditions,	b					\sim	1 1			
routed and transit	Examiner	if any, leading to immediate cause. Linter Underlying Cause (Disease or linjury that initiated events	C. Due to (or as a c					ALG	Jule	ICH E	CAMPIER	
760 icate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a o	conseque				CERTIFICATION AP	PROVED BY MILL			
Box 68 death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal of	death 3	Ectopic pregni Other (specify)					23d. Date of del Month	ivery Zan
P.O. That the that the need by e detail	y Pi	Part II. Other significant conditions of	contributing to death but	not result	ting in the ur	iderlying cause	giver	n in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
ds, P quires th en signe	ted	PNEUMO	NIA						1 🗆	Yes 2	2 Ø No 3 □ Pi	robably 4 🗌 Unknown
Records, P.O. The law requires that the cate has been signed by page 2 should be detact	Completed by	Pelvic Fra	cture						24a. Was auto perfo 1 \(\sum \) Yes		prior to death?	topsy findings available completion of cause of
Vital Vital vysician is certifi	o Be	25. Was case referred to medical examiner? 1 X Yes 2 1	Hospital:		D/O 4 - 1'	10	. Plac Other:	ce of Death (Chec			а П он — ю	
of of of of of of of of of of of of of o	te: To	27. Manner of Death	1 Inpatien 28a. Date of injury (Month, Day,	2	8b. Time of	28c. In	njury a	at	ome 5 ∟_Resi 28d. Describe l		6 Other (Specury occurred	iry)
ion tendin leath. tor: Aff	Certificate:	1 ☐ Natural 5 ☐ Pending 2 ▼Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	07/24/20	11	Found: 11:00	a ^M 1	☐ Ye	es 2 🔀 No	Subject			
Division of Vital tal or Attending Physician: as after death. as after death and birector. After this certific ed in by the funeral director.	al Cert	4 Homicide determined			e, farm, stre	et, factory, offic	ce		28f. Location (S City or Tov 2822 Ca	Street a vn, Stat rro	nd Number or Rui te) Il Stree	t, Balto,MD
Division of Vital Reco Division of Vital Reco To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director, Tetr this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nur	sician: To the best of m iner: On the basis of exa se Practioner: To the be	mination a	ind/or investi	gation, in my op	oinion,	, death occurred a	t the time, date a	and plac	ce, and due to the	cause(s) and manner stated.
To with		29b. Signature and title of certifier	Cep	-	- MO	29c. Lice	ense n	number 25844	,	29d. D	Pate signed (Month	7, 2011
8		30. Name and address of person who	completed cause of dea	th (Item 2	3a) (Type, Pr	int) 54/1	ر در پ	OLD FI	REDER.	erc)	21229	18
Sta Registr	te ar	CHKIS DAF 1. Co	Registrar's	Signatur	* par	KN						

11-06001

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State of Maryland / Department of Health and Mental Hygiene Nathan S. Krasnopoler Certificate of Death 1- For State 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 10, 2011 0700 hrs KRASNOPOLER **Medical Examiner** NATHAN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Gilchrist Hospice Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Country) **Funeral** Hours Months Davs 09/06/1990 MD Director 1X M 2 F 20 213-31-2678 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No ELLICOTT CITY or items 23a or 28a-f show must be notified at once. HOWARD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departnet of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g, Citizen of What Country? 10e. Street and Number USA 21042 3833 DAHLGREN COURT 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 1 Yes WHITE Specify. 1 Yes 2 X No specify: If Yes. Give Year Divorced 3 Widowed ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT MD 21215-0036 STUDENT 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COHEN SUSAN KRASNOPOLER æ MITCHELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21042 3833 DAHLGREN COURT, ELLICOTT CITY, MD MITCHELL KRASNOPOLER/FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 08/12/2011 HEBREW YOUNG MENS Donation 5 Other Specifi SOL LEVINSON & BROS., INC. nature of Funeral Sewice Liven 8900 REISTERSTOWN ROAD, PIKESVILLE, Approximate Interval ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complication een Onset and **Physician** failure. List only one cause on each ine Death /Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED **AMENDED** attending physician a for use as the burial -23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ۵ 24b. Were autopsy findings available Completed 24a. Was an has been prior to completion of cause of autopsy performed? death? Yes Yes 2 🗸 No certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Other Hospital: 1 / Inpatient 2 DOA ER/Outpatient 3 this 1 Yes 28a. Date of Injury 28d Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death After Operator of bicycle to auto collision Certification: Feb 26, 2011 1150 hrs 1 Yes 2 V No within 24 hours after deau.

To the Funeral Director: A 1 Natural 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 100 W. University Parkway, Baltimore, MD 3 Suicide Could not be determined (Specify) Roadway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c 1 icense number 29b. Signature and title of certifier August 11, 2011 O.C.M.E. cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

25906 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:30 PM Maus 11/2011 nonis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ri BYYO 00 R Cesu If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Jan, 1949, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 217-84-7678 1 □ M 2 🖫 F 92 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinar intra Legicular at 1 Yes 2 No MD Baltimore Phoenix Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13522 Jarrettsville Pike 21131 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3[™] Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hyy important: If item 27 is marked other any injury or other traumatic contents. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Makauskas Anna Lazaunikas 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kostas Krywonis (Son) 13522 Jarrettsville Pike, Phoenix, MD. 21121 20b. Place of Disposition (Name of cometery, crematory or other place)
Holy Redemer 20c. Location - City or Town, State 20a Method of Disposition 1 xBurial 2 ☐ Cremation 3 ☐ Removal from State 8/15/11 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Loudon Park Funeral Home once. 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kus **Physician** evenio resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Completed by Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy lor Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No detached P.O. the 9□ Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, should be 2 No 1 ☐ Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 No Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending atural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of scrson who completed cause of death (Item 23a) (Type, Print) Le mins 31. Date filed (Month, Day, Year) -32. R State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2011 4:54 A Lafferty August Daniel Adrian Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Year) 939 April 21 1 🕅 M 2 🗆 F Months 213-36-7934 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Example. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 🛣 No Baltimore Towson Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral U.S.A. 608 Sussex Road 21286 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 K Married þ 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Financial Corporate Accountant years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Elizabeth Frank John Edmund Lafferty, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21286 608 Sussex Road Towson, Agnes Lafferty 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 8-15-11 Baltimore, Maryland Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
4500 York Poad Raltimore, Maryland Signature of Funeral Service Licensee 21212 6500 York Road 23a. Part 1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset a d Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months? Yes 2 No 1 L Yes 2 L 9 L Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed 1 ☐ Yes 2 ☐ No Yes 2 1Ho 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗌 Ner 2 1 🗌 Yes 4 Nursing Home 5 Residence 6 Cother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 71040

Registrar

DHMH 17 Rev 7/2009

State

ST

SUITE 4105

2120

BALTIMORD MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMAR

6701 NCHARLES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 201^{Yea} ма 00:8 Lewis Richard 11 Aug Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 3408 Glenside Drive Baltimore Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 10-26-1 🔀 M 2 🗆 F 212-36-9175 **Director** 69 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville 1 Yes 2 X No MD Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3408 Glenside Drive U,S,A, 21234 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 9 Yes 2 X No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) A. Bauer & Company Owner Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lewis Andrew Jackson Cecelia Bauer Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Jane Lewis - wife 3408 Glenside Drive Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 8-15-2011|Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 21. Signature Fuperal Service Jaco 22. Name and Address of Facility Joseph N. Zannino Jr. 263 Conkling St. Baltimore, Md. S. 23a. Part 1. Enter the disea plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure Immediate Cause (Final Interval Between Onset and Death emcu Physician/ ag disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated secret. Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Investigation Accident Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a

State Registrar

completed

Medical

29a. Certifier

(Check

4 RTHUR

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 6

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month & Year inda, L. Mortimer 4:08 A 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltmore N/A at Maryland Medical Center 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Director Col AL Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1312 N. Mount St. 21217 USA 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 Divorced Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Little Italy Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Otis Mitchell Louise Richardson 19a. Informant's Name/Relationship (Type, Print)
Belanda Ford / Daugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1312 N.Mount St., Balt., MD 21217 Ford/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If its any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Balt.,CTY,MD King Memorial PK 4 🗌 Donation 5 🔲 Other (Specify) Signature of Funeral S 22. Name and Address of Facility Hari P., Close F. Sys. PA 5126 Belair Rd, Balt., MD 21206-5105 ice Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Due to for as a consequence of): heart disease or condition Medical resulting in death) Examiner 10 years Coronary artery disea Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequent Examin attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. signed by the atter in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 hypotensim Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? diabetes 24a. Was an the Funeral Director; After this certificate has appleted filled in by the funeral director, page 2.3 autopsy performed? Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 🗌 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes Accident Investigation 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar only one)

29b. Signature and title of certifier

apsin MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

igh Greene St

1871728709

Buttimore, MD 21201

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9918 8-19-11 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mason Sr. Wilson 2011 11:05a M 80 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Baltimore 8. Date of Dryn Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Davs Hours Min 91 **Director** 06 VA 230-12-1150 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore MD NA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 5214 Norwood Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married Married 1 Ves 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade na Rarber Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Mason Ella Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Park Ave Apt 304, Baltimore, Md 21201 Kevin Mason-Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Vet.8/19/2011 Owings Mills, Md son 21. Signature of Foneral Service Lice 122. Name and Address of Facility ala 21215 Baltimore, Md 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perform 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 **N**o ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Wursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of cep m1) D31464

State Registrar 821

MD 82
Registrar's Signature

N. EUTAW ST FINTE 308 Balkmore MD

2/20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-06047 Walter Merryman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25911

_			1- For State Registrar	Certificate of	Death	R	eg. No.	
Phys edical Exa		ıer	1. Decedent's Name (First, Middle,Last) Walter Joseph Merryman aka		alter Merryman	_ i .uguet .	Day Year 1, 2011	3. Time of Death 1326 hrs
			4a. Facility Name (if not institution, give street and number) 3939 Roland Avenue Apt 805		4b. City, Town, or Location of I Baltimore	Death	4c. County of Death	1
Fune Direct			215-44-0301 XXM 2 F	e (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min	rth (MM/DD/YYYY) 9. Bir 6, 1944 Co	
ADE		<u> </u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits
Maryland 28a-f show anv	00CC	ğ	Maryland	Baltimo				1XX Yes 2 No
th the 1	ast be ootified at ooce.	Dire	10e. Street and Number 3939 Roland Avenue		10f. Zip Code 21211		Og. Citizen of What Cou United Sta of America	ates a
er death wi	r must be	Fune	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No If Ye	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P		o- 14. Race - Amer White, etc. Specify: Whi	ican Indian, Black,
ours aft	ramine	<u>ğ</u>	15. Decedent's Education (Specify only highest grade comp	pleted) 16a. Decedent	t's Usual Dccupation (Give kin		16b. Kind of Business/	
5-0036 lled within 72 h Hygiene.	Medical E	Completed by	Elementary/Secondary (0-12) College (1-4 or 5-12th	+)	ost of working life. DO NOT us Machinist	e retired)	Black &	Decker
1215-C d be filed v lental Hygi	atic eveot, the Medical Examiner	a	17. Father's Name (First, Middle, Last) Benjamin Merryman		Sall	Name (First, Middle, y Sklar	1,500	
MD 2121 d 2 should be fi lth and Mental n 27 is marked	ımatic	— JI	19a. Informant's Name/Relationship (Type, Print) Stephanie A. Coleman (Daugh		Address (Street and Number Buchanan Ave.,			, Zip Code)
Fe, F s 1 and of Healt If item	other traumatic	- [3	20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State	20b. Place of Disposi	ition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 an Department of Heal	y or oth		4 Donation 5 Other Specify: 21. Signature Fuper Service Lands	Evergreen	Mem'l Grdns			
Ba perm Depa	injury	1	AM Semaunz.	32	ame and Address of Facility 96 Charmil Dr	., Manches	ster, MD 21	
Physicia /Medic		1	23a Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	he death. Do not enter th	ne mode of dying, such as card	liac or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
Examin			AtherDsclerotic Cor or condition resulting in death) a. AtherDsclerotic Cor or condition resulting in death)		ease			Death
	H		Sequentially list conditions, if any, leading to immediate	quence of):				
		틸	cause. Enter Underlying Cause (Disease or injury that initiated				_	
ecuted	표 .		events resulting in death) Last Due to (or as a consected by the consected	quonos ory.				
760, icate be executed physician and	burial	Medical	UNPENDED AMENDED FFEMALE: 23c. If yes, outcome					
6876 ertifical	e as the	ician/M	3b. Was decedent pregnant in the past 12 months?	2 Fet	al death 3 Ectopic pr	egnancy	23d. Date of delivery Month	/ Day Year
on of Vital Records, P.O. Box 68: eveding Physiciae: The law requires that the death certifi ath. or: After this certificate has been signed by the attending	ed for use as t	Physic	1 Yes 2 No 9 Unknown 9 Unknown	or death 5 Oth	ner (Specify)			
F. P.O. ires that the signed by	detach	g G	Part II. Other significant conditions contributing to death Chronic Alcoholism	but not resulting in the ur	nderlying cause given in Part I		obacco use contribute to	
rds, required	ould be	eted	Onlone Alcoholish			24a. Was	an 24b. Were au	topsy findings available
of Vital Records, og Physiciae: The law requir offer this certificate has been s	age 2 sh	Completed	-			autop perfo 1 ✔ Yes	rmed? death?	completion of cause of
tal Recision: The		Be C	25. Was case referred to medical examiner?		26.Place of Death (Ch			
of Ving Physical After this	편 1	의	1 Yes 2 No Impatien 27. Manner of Death 28a. Date of Injury	y 28b, Time of In			Residence 6 🗹 Other	: Scene
	å :	atio	1 V Natural 5 Pending 2 Accident Investigation (Month, Dey,Yea	ar)	1 Yes 2 No			
Division To the Hospital or Atteodic within 24 hours after death. To the Fuoeral Director: A	filled in b	5	4 Homicide determined (Specify)	ry - At home, farm, stree	t, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Ru state)	ral Route Number, City
To the Ho within 24 !		ल् ि	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam					
A S A	3	2	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	nth, Day, Year)
il	F		() alules M		O.C.M.E.		August 12, 2011	
		1	Laron Locke MD. Assistant Medical Exar		ltimore Street, Baltimo	re, MD 21223		
Reg			31. Date filed (Month, Day, Year) 32. Registrar's	s Signature				3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Carroll 12:40 P.M Nugent August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, ^{Year)} 1923 Hours Maryland 217-12-6661 **Director** 88 Jan Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ years Elementary/Seconday (0-12) Purchasing Stationary Store Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Owen James Nugent Margaret Scott Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne LoPiano 684 Concerto Lane Silver Spring, Maryland 20901 (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8-17-11 Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility feld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, beautiful immediate cause. Enter Underlying Cause Disease or iinjury Examiner Due to lor as a consultience of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, Al 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier p.o° 08-12-2011 Ne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS 2300 DULANEY VALLEY ROAD TIMONTIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 5 2011 Registrar

NUGENI

ROBERT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2591 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Andra Norris Month 3:15 P.M August 9 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death 18503 Sweet Autumn Drive #204 Gaithersburg 5. Social Security Number 6 Sex **Funeral** . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🖾 F Months Min. 579-86-1847 48 Hours **Director** Washington, D.C 02/23/1963 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Montgomery Gaithersburg 1 🙀 Yes 2 🗌 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18503 Sweet Autumn Drive #204 20877 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4XXDivorced Specify. Completed Specify: **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mea Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Helen Bernice Norris Andrew Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code) 20910 Devona Cole (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Lincoln Mem. Cemetery 08/16/2011 Suitland, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home, Inc. 20011 4217 9th Street, N.W. Washington, D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ End Stage Renal Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Dav Year ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate I performed' 1 ☐ Yes 2 🛣 No Yes 2 XNo director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0056067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Matthew Cooper, M.D. UNiversity of Maryland 21201 295 Green Street Baltimore, Md.

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARIE OWENS AUGUST 2011 10.110A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days (Month, Day, Year Director 66 212-48-6025 1944 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 700 Toll House Ave. 21701 U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No or i Completed by Black, White, etc 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene.
Item 27 is marked other than "natural", or 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 Divorced Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) children's daycare 12 teacher's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luvear Ernest Owens Sr. Nellie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria J. Owens/ daughter 91 Wimert Ave. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State . Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) AllCounty Cremation 8/16/2011 Sykesville, MD 21. Signature of Fund al Service Licens 22. Name and Address of Facility Hartzler Funeral Home ati Jarine Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Pulmanan acred disease or condition Medical resulting in death) Due to (or as a con-equence of): Examiner end 10 myo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Completed by Physician/Medical Box 68760 attending for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death a 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No al or Attending Physician: The safter death. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Suicide Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined I filled i 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29b. Signatu 29c, License number DG0417 MN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 2170) 65 temen shah Thomas Tourson Dr.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 1, per phy, g918 8-12-11 sm
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Chance Palmer 2. Date of Death AVEUST **Physician** 5:30 CHANCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BYLINGUE MEDICAL CONTOL BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 50x 1 M 2 □ F Months Days JULY MARCYCANI 2011 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Micologi Exemples result by recition at 1XYes 2 No Director Maryland n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2951 Keswick Road **USA** 21211 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H Be 2 Derek William Palmer Palmer Karin Mo1z 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2951 Keswick Road, Baltimore, MD 21211 Derek & Karin Palmer/ Parents Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If Ite 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) 8/12/11 Glen Burnie, Maryland Atlantic Crematory 21 Signature of Funeral Service License 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or southion resulting in death) a NECKETHING **Physician** ENTEROLDUTIS HOURS /Medical Examiner 12247 KESILLATORU DISMESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sicien and burial-transit DHYS To the Hospital or Attending Physician: The law requires that the death certificate be executed PREMITANTUR Box 68760. Physiclan/Medical the as esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 10 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical etely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MID AUGUST 2011 Melbering 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHEVIPLE BALTIMINE MEDICAL COWITM SIREWISHUM MIN MAY LAND ONLIMONE 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State facels) Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 07^{Day} 2011 2245 Helen 0. Pickett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Birthplace (State or Foreign Country)
 TTT7 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months (Month, Day, Year) WV 936 Director 578-52-3085 74 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No DC Washington 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? ō Funeral items 23a USA 5215 Just Street NE 20012 permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "man any injury or other "man". 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedo... Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 1 🗆 Yes 2 🔀 No If Yes, Give Year or Dates Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry Local 47 Union life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) District Council Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) ပ Hattie Darcus Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 School St. Barrackville, WV 26559 Sarah Darcus/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Pk 08/15/2011 Landover, MD Signature of Funeral Service Licentee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsv 25. Was case referred to medical 26. Place of Death (Check only one) l e examiner? Hospital Other: ٥ 1X Yes 2 🗌 No Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) in 24 hours after deau... he Funeral Director: After the meted filled in by the funeral 28c. Injury at work?
1 \sum Yes Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending Natural 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one)

State Registrar 29b. Signature and title of certifie

s of person who

5

30. Name and add

31. Date filed (Month, Day,

ompleted cause of death (Item 23a) (Type, Print)...

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUG. 11 2011 ear 4:30A M POLLACK RUTH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD 5507 VANTAGE POINT ROAD COLUMBIA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Min Hours 11-10-1929 217-24-1253 81 MD Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Yes 2 XXV HOWARD MD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Funeral with 23a 5507 VANTAGE POINT ROAD 21044 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 24 No Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify. WHITE "natural" 3 Widowed 4XXDivorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SNYDER DAVID GLASER EDNA permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5507\ VANTAGE\ POINT\ RD;\ COLUMBIA,\ MD\ 21044$ LYNN FOEHRKOLB / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
ARLINGTON CHIZIK
AMUNO BALTIMORE, MD 8-12-2011 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 Approximate Interval Between Onset and Death 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 M Ph_sician/ disease or condition Medical resulting in death) Due to s a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No the detached Unknown 9 Unknown s been signed by the should be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 1 🗌 Yes 2 🗌 No this certificate **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) nd title of certifie 29b. Signatu 29c. License number

101

State Registrar Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clemen Bernard Knight 10710 Charter DR. G020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ 9:58PM Robert Hoover Royster, Sr. Medical ugust 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FutureCare - Old Court Baltimore Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 1 M 2 - F Months |218-26-3383 78 North Carolina Yrs. Director Usual Residence of Decedent 28a-f show 10d. Inside/City Limits 10a, State 10b. County 10c. City, Town or Location must be notified at Director MD N/A 1 Yes 2 No Baltimore 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2624 Violet Avenue USA 21215 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Eyer in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 1 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Fork Lift Operator Unknown traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Susie Beth Jones Robert Burnette Royster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5304 Lantern Court Baltimore, Maryland 21229 Lakeisha Royster - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌃 Cremation 3 ☐ Removal from State cemetery, crematory or other place, Green Mount Cemetery | 8/15/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Faner I Sovice Liousee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (o Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Unknown Yes 2 No been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medica director, Be 26. Place of Death (Check only one) Other: 1 Tes 2 1 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 24 hours after death.

Funeral Director: After thi eted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 🗹 Natural 5 Pending work' 2 🗌 No 1 Tes Accident Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете (Check Medical Examiner: On # examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur title of c 29c. License number 30. Name and (Item 23a) (Type address of person who completed Print) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25919 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Augenth Mildred Frances Ross 1 Bay 201 Yapar 12:20p M Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll **Examiner** Sykesville Copper Ridge 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 🕌 Months Davs Hours November Pay Year 917 Maryland 214-38-3398 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔏 No Maryland Carroll Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 Funeral 710 Obrecht Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 10 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) 4 College (1-4 or 5+) Elementary School Teacher Baltimore Co. Schools Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Byron Lippert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codel 11630 Red Run Blvd. Reisterstown, MD. 21136 19a. Informant's Name/Relationship (Type, Print) Sharon Koenig - niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evergreen Mem. Gardens Aug. 17,2011 1 N Burial 2 Cremation 3 Removal from State Finksburg, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lokhardt Funeral Chapel F.A. 21. Signature of Funeral Service Lig-11605 Reisterstown Rd. Owings Mills, MD. 21117 . Harth Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -Physician/ 10 WS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Day Month 4 ☐ Pregnant at time of death g ☐ Unknown ed by the a detached f g Unknown as been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has page performed within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 17005994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

toner

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AUG 1 5 2011

31. Date filed Month, Day, Year

Suite 307

wsminster

11-058	393
Dusty	Spreng

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ousty opieng		Slate I- For State Registrar	e or iviaryland	-	tificate of l		nu Mentai		Reg. No. 20		25920
Physician	1/	 Decedent's Name (First, Middle,La 	•			******		2. Date of De	ath		3. Time of Death
Medical Examin		Dusty Ryan Sp. 4a. Facility Name (if not institution, gi			145	City Town	or Location of De	Month August 6	6, 2011 4c. County o		0455 hrs
		Peninsula Regional Medi				Salisbury	or Location of De	atri	Wicomic		
Funeral Director				e (In yrs. Ia	st birthday) Yrs.	If Under 1 You Months Da		/lin	3irth(MM/DD/YYYY) 7/75	9. Birth Foreign Cour	i
any	ŀ	Usual Residence of Decedent 10a. State 10b, County		10c. City,	Town or Location	ı	<u> </u>				10d. Inside City Limits
and f show	اة	MD Wicomi	.co	Sa	lisbur	У				1	1 Yes 2 X No
ith the Maryland 23a or 28a-f sho motified at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Count	ry?
vith the s 23a o	ল ⊦	817 Smith Stre	12 Was Decedent	Ever in U.S	3. 13 Was	2180	1 Hispanic Origin? (Specify Yes or N	U.S.A.	- Americ	an Indian, Black,
fter death ", or item er must b	-En	1 X Never Married 2 Marrie	d Armed Forces? 1 Yes 2 d If Yes, Give Year		If Yes		an, Mexican, Pue		White	, etc.	ite
nours a	2 P	15. Decedent's Education (Specify of	·				pation (Give kind ife. DO NOT use		16b. Kind of Bus		
215-0036 see filed within 72 hours at ral Hygiene. keed other than "natural men, the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 9	5+)	Offic			icino u)			Security ernment
5-00 ed with lygience other	5	17. Father's Name (First, Middle, Las			OTTIC	ET	18.Mother's Na	me (First, Middle	, Maiden Surname)		
21215-0036 ald be filed within 7 Mental Hygiene marked other than c event, the Medica	8	George Spreng					4		ry Roma		
MD 2 d 2 should d 2 should lth and M n 27 is m umartic	- 1	19a. Informant's Name/Relationship (George Spreng			19b. Mailing A 3024 FL, 3	Haven	Gate [or Rural Route No Or., Gr	umber, City or Town Cen Cov	i, State, 2 e S]	Zip Code) prings,
2 - S = F = F		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other Specification 3			lace of Disposition	on (Name of o	cre.8	Date /12/11	20c. Location - Green Florid	Cove	own, State e Springs
Baltimo permit. Page Department of Important: injury or oth	Ì	21. Signat of Fineral Service Lice			22. Na	me and Addre	ess of Facility R	ussell			Rest F.H.
	-	23a. Part I. Enter the disease, or com	unlications that coursed	the death	231	5 Sar	ndridge	Rd.,GI	reen Cov	re S	prings, FI Approximate Interval
Physician /Medical xaminer		failure. List only one cause on e Immediate Cause (Final disease a or condition resulting in death)	each line.	ic (M	orphine		xication		irest, shock, of flea		Between Onset and Death
Mayor of May		Sequentially list conditions, b		squerice or)							
	١⊒	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of)):						
uted nd ransit	X	events resulting in death) Last	Due to (or as a conse					https://www.			
760, Gate be executed g physician and the burial - transit	Medical	X UNPENDED	AMENDED 23a	1,27,2	28a-f pe	er me g	920 10-	13–11 vt			
P.O. Box 68760, that the death certificate be need by the attending physic detached for use as the burner.	Physician/Me	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 Live birth Pregnant at		2 Fetal	death 3	3 Ectopic pre	gnancy	23d. Date of o	delivery Da	ay Year
BO ne deat the att	S	1 Yes 2 No 9 Unknow	9 Unknown						N .		
P.O. P.O. By that as that gened detected	6	Part II. Other significant conditions	contributing to death	but not res	sulting in the und	derlying caus	e given in Part I.	_ 1 □ Y	Land ha	_	ne cause of death? ably 4 Unknown
Division of Vital Records, Ital or Attending Physician: The law requires as after death. In Director: After this certificate has been sign of the functal director, page 2 should be the fine of the functal director, page 2 should be the fine of the functal director.	Completed						· · · · · · · · · · · · · · · · · · ·	- per	opsy pr formed? de	rior to co eath?	opsy findings available ompletion of cause of
tal Recting The certificate ector, page		25. Was case referred to medical				26.Pla	ce of Death (Che		2 No 1	✓ Yes	2 No
Vital hysician this cert		examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 i	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Residence 6	Other:	
- = . \all a		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day,Y	ear)	28b. Time of Inju	` ₁ _	njury at Work? Yes 2 X No	28d. Describe	e how injury occurre	ed	
iSiO	<u> </u>	2 Accident Investigat	28a Place of In		d 4:00p me, farm, street,			unkno 28f. Location		r or Rur	al Route Number, City
Div	Certification	3 Suicide 6 X Could not determine	t be	resid				or Town,	State) 5125 Maryland		
1 0 - 7 5	₹ ·	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	cian: To the best of my er:On the basis of exar and manner stated.								
H S H S	Ĕ	29b. Signature and title of certifier					nse number	OCME	29d. Date signe		th, Day, Year)
		Thedan Me	. King:	TA.	m. D.	0.0	C.M.E. 	DOME	August 7, 2	011	
D		36. Name and address of person who Theodore M. King, Jr., MI				00 W. Balt	imore Street,	Baltimore, N	MD 21223		
Stat	-	31. Date filed (Month, Day, Year)	32. Registrar	r's Signatur							
Registra	ш	AUG 1 5 2011 /	mena p.	18	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:38 P M August 2011 Thomas Frank Soper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lorien Nursing & Rehabilitation Ctr. Taneytown 8. Date of Birth (Month, Day, Year) Mar 17, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) Funeral 1 🛛 M 2 🗆 Months Days Hours 212-24-5965 84 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2 X No Keymar Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral U.S.A. 21757 840 Francis Scott Key Highway items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗆 No 1945-45 Black, White, etc. 0 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural" 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) clothing factory 9 material cutter Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hy ht: If item 27 is marked oth y or other traumatic even 17. Father's Name (First, Middle, Last) Mildred Ramsburg Frank Thomas Soper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) T. Michael Soper/ son P.O. Box 63 Keymar, MD 21757 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State nr.Libertytown, MD 4 Donation 5 Other (Specify) Chapel 8/12/2011 Cemeterv Sign fur of the PI Service Licensee 22. Name and Address of Facility Hartzler Funeral Home Woodsboro, S Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine ed by the attending physician and detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 autopsy performed? Yes 2 N sidemia 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: 2 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred After work?
1 Yes 5 Pending injury 2 🗆 No Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier H0061206

State Registrar 30. Name and address of person who completed of

5 2011

Date filed (Month, Day, Year)

Poole Rd. Westminster MD 21157

Kelly Bria	n Thompson	
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State of Maryland / Department of Health and Mental Hygiene

(elly Br	ian Thon		1- For State Registrar		f Maryla #11 f	er F	epa Cer	rtment of	Healt Death	and	Menta			eg. No.	201		
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	II Exaiiii	1161	Kelly Bria 4a. Facility Name (if not inst					T	4b. City, To	wn, or Lo	ocation of	Death	August 7,		ounty of D	eath	
			607 Wood St	-					Brook	yn				Anı	ne Arun	del	
	Funeral		5. Social Security Number	6. Sex		7. Age (li	n yrs. la	ast birthday)	If Under	1 Year Days	If Under:	24Hrs. Min.	8. Date of Bir		F	. Birthj oreign	place (State or
	Director	L	213-92-7021	\$ 7 2 MAI	2_F	33	3	Yrs		Days	riours	IVIII I.	Jan.2	9,19	78	Cour	try) MD
	any	H	Usual Residence of Decede 10a. State 10b. Cou			100	c. City,	Town or Locat	ion							1	Od. Inside City Limits
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	hours after death with the Maryland 'natural", or items 23a or 28a-f sho Examiner must be notified at once.		607 Wood 5	treet	<u> </u>					2	1225	j			U	SA	
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	5 . L		3 X Widowed 4	Divorced If	1 X Yes Yes, Give Yes		No	1	Yes 2	No	specify:			S	pecify:	3 1 a	ck
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903	within giene. her th	ompleted	12th Grade 17. Father's Name (First, Mi	ddlo Lost)				.1	ruck				First, Middle, N	I	J.B.	HU	int
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21;	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical injury or other traumatic		19a. Informant's Name/Rela					19b. Mailin	g Address	(Street	and Numb	er or Ru	ral Route Num	nber, City	or Town, S	State, 2	Zip Code)
MD	alth an		Darleen Tho	mpsor	n/ Mo	ther		5632 Place of Dispos					Data		cation - Cit		MD21212
Baltimore,	es l ar of Hea If ite	П	1 X Burial 2 Crem	ation 3	Removal fr	rom State	۰	rematory or ot	her place)		8/	13/	711				
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			or condition resulting in dea	tn) Du	e to (or as a	a consequ	ence of	f):									
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	be executed sician and urial - trans	dical	UNPENDED		AMENDED												
6876	eath certificate t attending physi for use as the bu	Ž	IF FEMALE: 23b. Was decedent pregnan		23c. If yes,		of pregr		etal death	3	Ectopic p	oregnan	ıcy		Date of de lonth	livery Da	y Year
9 X	eath cert attendir for use a	sicia	past 12 months?	Unknown		nant at tim	e of de	-44	ther (Speci	fy)							
Box	that the dea led by the a detached fo	Physician/M	Part II. Other significant co		9 Unkn		ıt not re	esulting in the	underlyina	ause div	en in Part	I.	23e. Did to	obacco us	e contribut	te to th	e cause of death?
P.0	The law requires that the death icate has been signed by the atter page 2 should be detached for u	2						3	, ,				1 Yes	2 🗸	No 3	Proba	bly 4 Unknown
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900	ne law te has ge 2 sl	d L									-	_		rmed?	dea		
<u> </u>	certificate ector, page		25. Was case referred to me						2		of Death (C	heck or					
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	Atten r death ector: by the	Cati	2 Accident	Investigation	28e Plac		/ - At ho	0908 hrs ome, farm, stre	et, factory.				28f. Location (Street and	Number of	or Rura	Route Number, City
Div	To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		Could not be determined				e / Rowhou					or Town, S 07 Wood St,	State)			
	Hosp 24 hou Fune rely fi		29a. Certifier 1 Certifyli	ng Physician	: To the be	st of my kr	nowledg	ge, death occu	rred at the	ime, date	e and plac	e, and c	due to the caus	se(s) and i	manner as	stated	I.
_	To the Ho within 24 To the Fu completely	Medical	one) 2 Medical	ar	n the basis nd manner s	of examin stated.	ation a	nd/or investiga		_		urred at	the time, date				
		Σ	29b. Signature and title of o	ertitier	,	0) ^		29c.	C.C.M					st 8, 20		h, Day, Year)
			30. Name and address of pe	Con.	CC-	TO(h (Item	23a)		J.J.IV			•	, aga			
	0					oc or dear		200)									
	2		Patricia Aronica-P	oliak MD.	Assist	ant Med	dical E	Examiner	900 W.	Baltim	ore Stre	et, Ba	altimore, M	D 2122	3		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	Maryland / Depa	artment of F tificate of D		, ,	2011	25923
			Registrar		- Incate of L	Jeaur	Reg. 2. Date of Death	NG UII	3. Time of Death
	Physicia Medic		Ernest Thompson	SL.		12	Month AUGUST	Day Year	4:00 P M
د. المدينة	Examin	ier	4a. Facility Name (if not institution, give street and num 7035 E. BALTIMORE 3.T.		4b. City, Town, or	Location of Death BALTIMO		4c. County of Dea	Å
	Funeral Director		405-38-2407 1 ^{1∆} M 2 □ F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 7—14—19	9. Bin 032 KE	thplace (State or Foreign suntry) SNTUCKY
	nd how at	۱	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla 28a-f s atified	Director	MD N/A			BALTIMO	RE		1 X Yes 2 □ No
	with the s 23a or 2	Funeral Di	10e. Street and Number 7035 E. BALTIMORE ST	REET	10f. Zip Code	21224	10g	. Citizen of What C	
920	e filed within 72 hours after death with the Maryland tral Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	[출	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	ces?	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sper an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
5-0	2 hour	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of working	16	b. Kind of Business	Industry
21215-0036	within 72 rgiene. ner than t, the Me	Completed	Elementary/Seconday (0-12) College (1-	4 or 5+) life. D	O NOT use retired) ELTVERY	BUDWEIS	ER		
Maryland	ould be filed within 7 ind Mental Hygiene. marked other than maric event, the M	To Be	17. Father's Name (First, Middle, Last) ROBERT	THOMPSON		18. Mother's Name	e (First, Middle, Maid ETH		KLIN)
	and is n		19a. Informant's Name/Relationship (Type, Print) MARGARET V. THOMPSON			and Number or Rural		ty or Town, State, Z	
ore,			20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cree	osition (Name of matory or other place	ce)	Date 20	c. Location - City o	r Town, State
Baltimore,	permit. Page 'Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	2:	REMATOR Name and Address	ss of Facility CVA	ACH/ROSE	CATONSV EDALE FU	NERAL HOME
			23a, Part 1, Enter the disease, or complications that co			SACO AVI		<u>·</u>	21237 Approximate
8	hysician/		shock, or heart failure. List only one cause on each	th line.		_			Interval Between Onset and Death
-	Medical Examiner		resulting in death) a. Due to (c	end-Stay		/ 1	J		
	n #	niner	cause. Enter Underlying	or as a consequence of					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events c. Due to (c.	or as a consequence of):					
09,	ate be ohysicia the bur	dical	d						
Box 687	ath certific attending for use as	Physician/Me	in the past 12 months?		Ectopic pregnand Other (specify)	су		23d. Date of do Month	elivery Day Year
ds, P.O.	requires that the des teen signed by the s srould be detached i		Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause gi	ven in Part I.	- 1		o the cause of death? Probably 4 Unknown
Division of Vital Records,	sician: The law ner certificate has t e irector, page 2 st c	Completed by					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of es 2 No
/ital	nysician iis certif directol	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	npatient 2 ER/Outpatie	Oth	er:	4	ce 6 ☐ Other (Spe	cifu)
n of \	ding Phys th. After this funeral di		27, Manner of Death 28a. Date of		f 28c. Injur	y at	28d. Describe how		City)
ivisio	or Atten after dea Director: in by the	Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, str g, etc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the be (Check 2 Medical Examiner: On the bas	s of examination and/or inves	stigation, in my opini	on, death occurred at	the time, date and p	place, and due to the	cause(s) and manner stated.
_	To the I within 2 To the I complete	1	only one) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier		29c. Licens	e number	290	I. Date signed (Mon	th, Day, Year)
O			30. Name and address of person who completed cause	e of death (Item 23a) (Type,	Print)	5700	3 Bala	throre M	111 021205.
V			N.J. Lin aprilCSE M.D. 31. Date filed (Month, Day, Year) 32. F	7835 Simi	in "		1000		1-0 /
	Sta Registr		AUG 1 5 2011	we did	and				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year 0255 2011 ominique Valentin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Univ of mo N/A Balhmore Shoch If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 1990Mary land **Funeral** 7. Age (In vrs. last birthday) 214-31-7541 1 M 2 D F Months (Month, Day, Year, 20 **Director** 11 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at **Funeral Director** Columbia Maryland Howard 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8370 Silver Trumphet Drive 21045 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. þ 1X Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CVS Customer Service Represen Year Be tative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Leon Valentine Stefanie Yvonne Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 21045 370 Silver Trumphet Drive _{Columbia}, Maryland Stefanie Y. Jones/Mother 370 Silver injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place Greenmount Cemetery 8/16/201 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Chatman-Harris FuneralHome | 5240 Reisterstown Rd Baltimore, MD 21215 Sociature of Funeral Scaling Lie Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final multiple. Physician/ disease or condition Due to (or as a consequence of): day Medical resulting in death) Examiner CERTIFICATION APPRIMED ST MEDICAL EXAMINER Sequentially list conditions, if any legislation cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonviguenna off the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the should be detached if 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Certificate: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 🗚 No 5 Pending injury 08/07/2011 0250 MVC rollover Investigation Could not be 3 ☐ Suiciae 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Street Rd Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Dav. Year) 8/11/201 D63939 person who completed cause of death (Item 23a) (Type, Print) MD 2120 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Month Year **Physician** 14:45p M Franklin Delano Wilde 08 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Port Deposit Cecil 52 Maple Hill Drive If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Year) Months M 2□ F PA 74 10/24/ 210-28-9215 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modon Examinar must be notified at 1 ☐ Yes 2 No Director Port Deposit MD Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 52 Maple Hill Drive U.S.A. 21904 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Production 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erma Jane Wertz James Russell Wilde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 52 Maple Hill Dr., Port Deposit, MD 21904 Mary Wilde (Spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Science Care 8/10/11 Aurora, CO 4⊠Donation 5 DOther (Specify) 22. Name and Address of Facility Science Care 21. Signatu 19301 E. 23rd Ave., Aurora, CO 80011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUNG CARLINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUCTOR LUNG DUEALE CHRONIC Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 □Yes 2 No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation al or Attend after death by the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

State

within 24 hours

29a. Certifier (Check only one)

29b. Signature and title of certifier

RAS V. PULA 126 A E. HIGH N AYANA filed (Month. Day, 1 5 2011

STREET

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100 65733

811

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

UD

MD 21921 ELKTON

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensura All Copies Are Legible. state of Maryland / Department of Health and Mental Hygiene 20 25926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 1:10AM WHITE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 237-50-3984 1 M 2 🗆 F Hours **Director** 1-27-Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director BAUIMORE MD 1 XYes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral Radnor AVENUE 21212 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑No ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) A.B.F. (PRIVATE) Elementary/Seconday (0-12) College (1-4 or 5+) TRACTOR TRAILOR DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ NATHANIEL WHITEHEAD UCY HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER RAdnor Ave. BALTIMORE, MD, 21212 Arlene F. White Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/17/2011 BACTIMORE, MD MD NATIONAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SENICES 21. Signature of Funeral Service Icensee NO 4905 YORK ROAD. BALTO, MD 21212 155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sephic Immediate Cause (Final Snock Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cram Negative Bacterenia Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last months Examir Tariffuse Due to (c) as a consequence of): arge Physician/Medical Sonal Gord Compression 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mac frome ation, congestive heart 2 No 3 Probably 4 Unknown 1 Yes Completed Cereborovascular Accident, PUD, PVD 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 No ည 1 Management 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title-of certifie 29c. License number KES 000 11/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 LOCH RAVAN BLVD, BALTIMORE, MD BLVD 5601 LOCH RAVAN 31. Date filed (Month, Day, Year, AUG 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•			ryland / Depa	artment of Health and Natificate of Death	lental Hygie	ne2011	25927
	_	_	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	unicate of Death		. No.	1
	Physicia Medic		Elizabeth D.		Washington	2. Date of Death Month 08	Day 2011	3. Time of Death 5:00a. M
	Examin		4a. Facility Name (if not institution, give street and number) 3915 Callaway Ave Apt 3	01	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral		1 DM 2 De	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		212-16-8484 Usual Residence of Decedent	92 Yrs		09 13	18	MD
	land show	tor	10a. State 10b. County	10c. City, Town or Loc	eation			10d. Inside City Limits
	Mary 28a-i	irec	MD NA	Balti				1 X Yes 2 No
	th the 3a or t be r	al D	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	
	ath w	Funeral Director	3915 Callaway Ave Apt 3		21215 Vas Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U.S.A.	
õ	fter de	by F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ N	lo If	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
9500-61212	ours al	eted	3 XWidowed 4 ☐ Divorced Year or Dates.		Yes 2 No Specify:	l III	Specify: Bla	
Ċ	72 ho an "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-4)	(Give k	ent's Usual Occupation ind of work done during most of work) NOT use retired)		b. Kind of Business In altimore	
717	withir rgiene ler tha		Elementary/Seconday (0-12) College (1-4 or 5-1 12th grade 2yrs		cretary	Pı	blic Sco	ools
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Mai	den Surname)	
Š	ould b		Langford Conn 19a. Informant's Name/Relationship (Type, Print) Daugh	t o 10 10h Mailin	Julia D		huar Tawa Stata Zin	Code 21117
Z	d 2 shualth ar		Julia Davidson Randall	L L	Reese Farm Ro			
ore,	of Head of Head if item		20a. Method of Disposition 1 Description 1 Removal from State	20b. Place of Dispos			c. Location - City or T	
saltimore,	Page tment tant: I jury o		4 ☐ Donation 5 ☐ Other (Specify)	1	orial Park 8/1	7/2011	loodlawn,	Md
gai	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licensee	22. M	Name and Address of Facility arch F/H West 300 Wabash Ave			
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente	300 Wabash Ave r the mode of dying, such as cardiac of	Baltin or respiratory arrest,	nore, Md	21215 Approximate
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	مراح ما ع	h- a			Interval Between Onset and Death
	Medical Examiner		regulting in death)	consequence of):	170			
	Examine	-Le	Sequentially list conditions, b.	ementi	٩			
	ed	min	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause (Disease or iinjury	consequence of):				
D	execut in and ial-trar	Exa	that initiated events c.	consequence of):				
20	e death certificate be executed the attending physician and hed for use as the burial-transit	dical Examiner	d					
200	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of	f pregnancy			001 001 011	
X Og	ath ce attend I for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 25c. If yes, outcome of the property of the pregnant at	Petal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
<u>п</u>	the de by the ached	hysi	9 Unknown					
Ţ.	es that igned be def	by	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause given in Part I.		cco use contribute to t	the cause of death?
ecords,	require been s should	eted				24a. Was an		opsy findings available
ecc	e has l	Completed				autopsy performe	prior to co	ompletion of cause of
ב פ	an: Th tificat tor, pa	Be Co	25. Was case referred to medical		26. Place of Death (Chec.	1 Yes 2 k only one)	No 1 Yes	2 ∐ No
Z	hysici nis cer I direc	To B	examiner? 1	nt 2 🗆 ER/Outpatien	t 3 DOA Other: 4 Nursing Ho	me 5 🛛 Residenc	ce 6 Other (Specif	·γ)
1 01	ling PI 1. After th uneral		27. Manner of Death 1 Natural 5 Pending 28a. Date of injung (Month, Day,	Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how	injury occurred	
SIO	Attend death ctor: / y the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injur	y - At home, farm, stre	M 1 Yes 2 No	28f. Location (Stree	et and Number or Rura	al Route Number.
UIVISION	al or / s after il Dire d in b		4 Homicide determined building, etc.		,,	City or Town, S		,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of recommendation (Check 2 Medical Examiner: On the basis of examiner: On the basis of examiner:	amination and/or invest	igation, in my opinion, death occurred a	t the time, date and p	place, and due to the ca	ause(s) and manner stated.
	To the within To the comply	Σ	only one) 3 \(\subseteq\) Certifying Nurse Practioner: To the beginning 29b. Signature and title of certifier	est of my knowledge, d	eath occurred at the time, date and place 29c. License number		use(s) and manner as s I. Date signed (Month,	
	•		1 Clubourno		D30942	8	/12/11	
	5		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P	BOLL MI	1 21215	- GDu Bon	no MPY
	Stat		31. Date filed (Month, Day Year) AUG 1 5 2011 32. Aegistrar	's Signature		- (1	/	
	Registra	ir .	AUG I U ZUII ZA	J. 190				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes

		•	1 - State Registrar Certificate of Death Reg. N.	2011 23920
Н	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month	3. Time of Death
	Medic	al	a	8, 2011 0620M
	Examin	er	4a. Facility Name (if not institution, give street and number), 4b. City, Town, or Location of Death 4c. City, Town, or Location of Death 4c. City, Town, or Location of Death	C. County of Death Prince George's
	Funeral Director		5. Social Security Number 228–2545 6. Sex 1 - Age (In yrs. last birthday) 1 - If Under 1 Year 1 - If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 13 1	9. Birthplace (State or Foreign
	how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	farylar 8a-f sl tified	Director	Washington	1 ¥ Yes 2 □ No
	a or 28	i Di	10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?
	th with ms 23 must	Funeral	5061 1st Street NW #204 20011 US	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 No	14. Race - American Indian, Black, White, etc. Specify: Black
2-0	72 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b.)	Kind of Business Industry
72	vithin 7 liene. rr than the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Engineer Ho	ousekeeping
pu	filed v al Hyg d othe event,	Be c		n Surname)
ya	uld be I Ment narke natic	υ	WITTE WATER	
<u>⊠</u>	2 sho Ith and 27 is r r traur		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of 2401 Kersey Ct. Greensboro, NC 2	1
re,	of Hea of Hea fitem		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. L	Location - City or Town, State
E E	. Page 1 Iment of I tant; If it jury or o		4 Conation 5 Other (Specify) Maryland National Mem 08/16/2011 Lau	
Ball	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March 4217 9th St. NW Washington, I	
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of):	Onset and Death
- Care	Examiner			
	7 ±	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	ecuted and I-trans	Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):	
0	ificate be executed ig physician and as the burial-transit	Medical I	d	
	tificate ng phy as the	_	LIFFEMALE.	
Box 6	requires that the death certi been signed by the attendin should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
л. О	requires that the been signed by the should be detach	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	use contribute to the cause of death?
, I	luires t en sign uld be	ed by	SALOKAN gland intection 1 - Yes 2	2 ─ No 3 ☐ Probably 4 ☐ Unknown
Kecords,	law req nas bee e 2 sho	Completed	Abdominal Acrtiz Anewysin 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ž	The ate pag			death? 1 Yes 2 No
Vıtal	sician certifi irector	Be c		аПац. (a. 1)
ō	Attending Physician: 7 reath. ector: After this certifice by the funeral director, c	te: To	T impatient 2 in Ery Outpatient 3 in ECA 4 in Nursing Home 5 in Residence	
<u>0</u>	tendin leath. or: Aff the fur	Certificate:	1 Natural 5 Pending (Month, Day, Year) Injury work?	
Division of	l or Atten after deat Director: I in by the	Cert	28f. Location (Street as building, etc. (Specify)	and Number or Rural Route Number, (e)
	To the Hospital or At within 24 hours after to the Funeral Direc completed filled in by	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) a	
	the Ho hin 24 the Fu	Mec		e(s) and manner as stated.
_	2 100		29b. Signature and title of certifier 29c. License number 29d. Di	Pate signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10 Jul 11 2011
			Solvador SylvaTer 3001 Hospital Drive, Cher	enly morglows
	Stat Registra			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N rtificate of Death		7011	25929
			Registrar 1. Decedent's Name (First, Middle, Last)	inouto or Bourr	Reg. 2. Date of Death	NO.	3. Time of Death
	Physicia		Gloria Regina Washington		Month 08 04	Day Year 4 2011	5:58 P ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Prince George's Hospital	Cheverly	I	Prince Geo	orge's
1	Funeral		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	g. Birth Cou	nplace (State or Foreign
	Director		194-52-8598		05/23/195	59 Penr	nsylvania
	ind show at	5	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	faryla Ba-f s tified	Director	MD Prince George's Hyattsvil	le.			1 X Yes 2 □ No
	the N	Ö	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?
	s 23s	Funeral	3965 Warner Avenue apt.#D6	20784	USA	A	
	death item ner n		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri Black, White	
36	after Il", or xami	d by	1 XNever Married 2 Married 1 Yes 2 XNo 3 Widowed 4 Divorced Yes Give	1 ☐ Yes 2 🛣 No Specify:		Specify: Blac	
Ö	nours natura ical E	Completed	Teal of Dates.	dent's Usual Occupation	16h	o. Kind of Business I	ndustry
215	n 72 t an "n Medi	mp		kind of work done during most of work O NOT use retired)	ing	. Time of Eddingson	, accury
7	withii giene er th		2 years CNA		U:	PMC	
Maryland 21215-0036	filed tal Hy doth event	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Sa	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1	Eugene Chapman		Washingt		
Mai	2 shooth and 7 is not traun	10		ng Address (Street and Number or Run			
	and 2 s Health tem 27		Trina Washington/Daughter 3965 20a. Method of Disposition 20b. Place of Dispo	Warner Ave., apt.		SVILLE, M c. Location - City or T	
Baltimore,			1 Burial 2 🖾 Cremation 3 🗌 Removal from State	natory or other place)	E /2011	est View,	
≢	permit. Page 1 Department of Important: If i any injury or c			h Crematory 00/1 2. Name and Address of Facility Mar			
ĕ	Dep Imp any onc	1/2		217 Ninth Street			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
e de	Ph _{sician/}	1 178	Immediate Cause (Final disease or condition	india arch	11 things		Ongot and Death
	Medical Examiner		resulting in death) a. Due to (or k a consequence of):		/		A
		r e	Sequentially list conditions, b.	- cover			Well H
	ed	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. con a			2000 Au
	certificate be executed inding physician and use as the burial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):	1	- /.		1
09	s be e sicial	dical	d respir	ator injul	freeze		doys
\sim	ificate ng phy as the	Med	IF FEMALE:	0	/		/
89 x	eath certifica attending p	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of deli	
Вох	deat the at ned fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
P.O.	at the	Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e, Did tobaco	co use contribute to	the cause of death?
S,	Attending Physician: The law requires that the death sr death. ector: After this certificate has been signed by the atte by the funeral director, page 2 should be detached for	d by			1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
ord	requ been shoul	Completed			24a. Was an	24b. Were aut	opsy findings available
ě	ician: The law certificate has rector, page 2	omp			autopsy	? death?	completion of cause of
E	an: Tl tificat tor, pa	Be C	25. Was case referred to medical	26. Place of Death (Chec	1 ☐ Yes 2/ X k only one)	No I Yes	2/10/100
Ĭ	lysician: lis certific director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie:	nt 3 DOA Other: 4 Nursing Ho	ome 5 🗌 Residence	6 Other (Speci	fy)
0	ng Pl		27. Manner of Death 1	f 28c. Injury at work?	28d. Describe how in	ijury occurred	
<u>o</u>	ittendii death. stor: Ai / the fu	ifica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or At after c Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St		al Route Number,
	spital lours heral l		29a. Certifier 1/X Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	nd due to the cause(s	and manner as sta	ted.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investorly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the c	cause(s) and manner stated.
	vithi To th	_	29b. Signature and title of certifier	29c, License number	29d.	Pate signed (Month	, Day, Year)
	ì		Ima A alles MI) V 4534		4 V9UST (5,2011
			30. Name and address of person who completed cause of death (Item 23a) (Type,	7	0 11 - 1	X/ C1.	All dis
	Stat		31. Date filed (MoMn, Day, Year) 32. Registrar's Synature	Prince Georg	ic mospin	al che	UC191 MID
	Stat Registra		AUG 1 5 2011 Comme B. Jank				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ 2011 1747 Ε. Medical Wayne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery <u>Silver Spring</u> 8. Date of Birth (Month, Day, Year) 02/24/1959 9. Birthplace (State or Foreign Country) Washington, DC Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. Funeral 1 **№** M 2 □ F Hours Director 216-78-9588 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified 1 ¥ Yes 2 □ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA ral", or items 2 Examiner mus 4606 Olden Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Yes. Give 3 Widowed 4 Divorced Year or Dates White Health and Mental Hygiene. cm 27 is marked other than "natur ther traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vernon David Bladen Estelle Electa Mastin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Helen T. Allinson-Bladen - Wife</u> 4606 Olden Rd Rockville, MD 20852 injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 08/02/2011 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) **Examiner** Lactic Acidosis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Undarlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transit Septic Shock resulting in death) Last Due to (or as a consequence of): physicians the burial Physician/Medical Fournier's Gangrene Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s after death.

Director: After this certificate has page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖺 No Hospital: Other: 1 🗌 Yes ည 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation npleted filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

Hospital or Attending Physician: The 24 hours a

State

29a. Certifier

only one)

29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1500 Forest Glen Road

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

07/28/2011

Silver Spring, MD 20910

29 c. License number D006727

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			for State of M state Registrar	laryland / Departme <i>Certifica</i>	ent of Health ar ate of Death		Reg. No.2 \cap 1	25021
	Physicia	in/	Decedent's Name (First, Middle, Last)	21.1		2. Date of Dea	th CUII	3. Time of Death
animan .	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	1 4 Cm	ity, Town, or Location of [724	Day Year 2011	4:00 a M
-	Funeral Director		Howard Caydy Go	rord forp.	Columbi	٩	How	cro.
			5. Social Security Number 481-20-9426 6. Sex 1 M 2	ge (In yrs. last birthday) 87 Yrs. If Un Month	der 1 Year If Under 24 ns Days Hours	Hrs. 8, Date of Birth Min. (Month Day 5 8		hplace (State or Foreign untry) OWa
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10a. State 10b. County MD Howard	10c. City, Town or Location Columbia				10d. Inside City Limits
			10e. Street and Number		Zip Code		10g. Citizen of What Co	1 Yes 2 □ No
			6905 Raven Lane		21044		USA	
			11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates.	AL -	cedent of Hispanic Origin pecify Cuban, Mexican, P s 2 Mo Spec <i>ify:</i>	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify:	
15-(15. Decedent's Education (Specify only highest grade completed)	life DO MOT	work done during most of	working	16b. Kind of Business	Industry
212		Be Co	Elementary/Seconday (0-12) College (1-4 or)+) Home	maker		Own Hom	e
land		To B	17. Father's Name (First, Middle, Last) Ernest Ward			Name (First, Middle, I le Daughe		
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (Type, Print) grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Black-Howell/Son 6905 Raven Lane Columbia, Maryland 21044					
			20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ★ Removal from State 4 ☐ Donation 5 ☐ Other (SpoAfy)	20b. Place of Disposition (*)	Vame of or other place)		20c. Location - City or Braintr	Town, State
Balti			21. Signatura truncial Service Licensee			LDI FUNEI Blvd.Si		CE,P.A. ng,Md20910
	Hospital or Attending Physician: The law requires tha 24 hours after death. Funeral Director: After this certificate has been signed sted filled in by the funeral director, page 2 should be de	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between					
Z			Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or n a consequence of):					
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events resulting in death) Last Due to be seen sequence of: Due to be seen sequence of: C. Due to be seen sequence of: Due to or as a consequence of:					
Division of Vital Records, P.O. Box 68760		1edical	d					
		Completed by Physician/	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 SNo 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 Ectop			23d. Date of de Month	livery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con 1 Yes 2 No					the cause of death?
						24a. Was a autop perfor	sy prior to med? death?	topsy findings available completion of cause of
		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpat	ient 2 ER/Outpatient 3 🗆	26. Place of Death		ence 6 🗆 Other (Spec	ifv)
		Medical Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Date of injunction) 2 ☐ Accident ☐ Investigation		28c. Injury at work? 1 □ Yes 2 □ N	28d. Describe h	ow injury occurred	·
							ocation (Street and Number or Rural Route Number, City or Town, State)	
_			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
			29b. Signature and the of perithr		29c. License number		29d. Date signed (Mont	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sq. (M. W. 2104)					
State Registrar AUG 01 2011 32. Registrar's Signature AUG 01 2011								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 01:52M 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner THE JOHNS HOPKINS BALTIMORE CITY HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 5 / 22 / 1960 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Days Min 137-64-8889 51 Director New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Frederick 28a-f Middletown with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3401 Marbury Ct. 21769 23a USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 10. Maryland 21215-0036 1 □Yes 2√□No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than "rr r traumatic event, the Wed Elementary/Secondary (0-12) College (1-4or 5+) software engineer aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Louis Bernhard Nancy Kolb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other traisonce. 458 Amblewood Way, Maria Truglio (Fiancee) State College, PA 16803 altimore, 20b. Place of Disposition (Name of _cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial /2 Cremation 3 L 4 Donation 5 Other (Special /2 Cremation 3 Removal from State Lutheran cemetery 7/30/11 Middletown, MD 22. Name and Address of Facility Donald B. Thompson Funeral Home POB 18 Middle frown MD 21760

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, additional suggestions of the property Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis

Due to (** as a consequence of): disease or condition resulting in death) /Medical Examiner fram Negative Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Irju) that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. signed by the a 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe of Vital 1 □Yes 2 No 1 □Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ After the 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide to the Hospital or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed [Month, Day, Year) 40501 RES-000 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe Street, Baltimore, Md 21287 Loubsel Kara 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MELLAL .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 10:25 A.M Ethel C. Burrier July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumbland Farms Frederick Frederick 8. Date of Birth (Month, Day Sept. 24 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 X F Days Hours Min. Mary land 215-26-0884 87 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Frederick 10f. Zip Code 21702 10e. Street and Number 10g. Citizen of What Country?
United States Funeral 7401 Willow Road items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (*First, Middle, Maiden Surname*) Lola Jane Martz Page 1 and 2 should be fil ment of Health and Mental ant: If item 27 is marked o ည William B. Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 94, Myersville, MD 21773 William G. Burrier / Son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 8/1/2011 4 ☐ Donation 5 ☐ Other (Specify) Utica, Maryland Utica Cemetery 21. Signature of Funeral Service License, Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the discase or complications that ca/ ex the death. Do not enter the mode of dying, such as cardiac or respiratory arrest trong one cause on each line. Approximate rck, or heart failure. Let only one can Interval Between Onset and Death Immediate Cause (Final Physician/ Dumel man disease or condition resulting in death) Medical Due to (or as a con guence of) Examiner Esquentially list sonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and that initiated events resulting in death) Last Due to (or as a consequence of): burial-t ing physician as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a Was an the Hospital or Attending Physician: The law prior to completion of cause of death? autopsy performed To the Funeral Director; After this certificate has page 2 1 ☐ Yes 2 ☐ No Yes 2 340 25. Was case referred to medica ector, 26. Place of Death (Check only one) Be examiner? 20 No Hospita Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending within 24 hours after death. М ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tithe of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of pers

Year

31. Date filed (Month

n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

record

300 West 9th Street, Frederick, MD 21701

MDD16428

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Cecil Robert Baltimore Julv 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 958 Security Rd. Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F 214-34-9220 Min. July 17 Director 74 Marvland be filed within /2 reconstructed by the filed within /2 reconstructed than "natural", or items 23a or 28a-f snow arked other than "natural", or items 23a or 28a-f snow are event, the Medical Examiner must be notified at Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Clarkson Ave. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Layer Masonry Company permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Baltimore Helen Butler Baltimore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Lewis-granddaughter 958 Security Rd. Apt. C Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Rest Haven Cemetery | 8-6-2011 4 Donation 5 Other (Specify) Hagerstown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home Kaitlin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Advanced 59 hamous cell disease or condition resulting in death) -ears Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or se a consequence on or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? dysphafia fo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe 2 🗆 No 1 🗌 Yes the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1X Natural 5 🗋 Pending e Hospital or Attendin, n 24 hours after death. e Funeral Director: Aft 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the pasts or examination arror investigation, in my opinion, year received at the time, date and place, and due to the cause(s) and manner as stated To the within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

JW−15 State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 P^{M} Ju1v 1:10 Ruth Rebecca Bever1v Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Calvert County Nursing Center Prince Frederick 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In yrs. last birthdav. Social Security Number If Under 24 Hrs. **Funeral** Mary land 1 🗆 M 2 🗶 09-20-1919 Director 91 217-36-9472 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 28a-f 1 ☐ Yes 2 🗓 No Calvert Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Completed by Funeral 23a USA 15 Well Street 20639 f Health and Mental Hygiene. item 27 is marked other than "natural", or items: other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sr. Ethel Ε. Cochran Benjamin Franklin Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice C. Williams, daughter 15 Well Street, Huntingtown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or o 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 08-02-2011 | Huntingtown, MD Huntingtown Church 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ resulting in death) Medical Due to (o **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a conse Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 🗌 Yes Yes 2 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: At 1 Tes 2 \square No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated соmpleted (Check Certifying Nurse Practioner: To the best of my knowledge, death oc curred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Athur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MonyULY LINA L. CROPPER ~28, 2ďT1 1855 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🗆 M 2 💢 F 3-27-1926 221-32-9568 PENNSYLVANIA 85 Yrs Director Usual Residence of Decedent ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🛣 No DELAWARE SUSSEX DAGSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30539 CROPPER'S LANE 19939 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BUSINESS OWNER CAMPGROUND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 is marked ot ၉ HOWARD LEMUEL LYNCH EDNA COLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If Item 27 is DAWN CROPPER CHANDLER/DAUGHTER 30545 CROPPER'S LANE, DAGSBORO, DE. 19939 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ROXANA CEMETERY 8-3-2011 FRANKFORD, DELAWARE 4 ☐ Dopation 5 ☐ Other (Specify) METSON TUNERAL SERVICES, LTD.
43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 23a. Part 1. Enter 1. c sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hea/fy lure. List only one cause on each line. Interval Between Immediate Cause Inal Onset and Death Physician/ hronic UbStructure disease or condition Medical resulting in death) Due to ur as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due (or a a consequence of): loxys pronon that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 / the attending ph ched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown Pregnant at time of death Day Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has page 2 autopsy performe death? the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1 🚅 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEALTHWAY NISAR

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

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1926

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>011</u> Physician/ July 30. Robert Stanley Cohen 0520 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number 6. Sex 1 **X** M 2 □ F Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) New York Months Days Hours Month, Pay, Year) 32 Director 79 128-26-0687 Usual Residence of Decedent or 28a-f show le notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 11562 Lockwood Drive 20904 U.S.A. "natural", or items idical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than 'e College (1-4 or 5+) Elementary/Seconday (0-12) Bill Collections Credit Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ည Max Cohen Rebecca Kaplan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Winding Way Lane, Silver Spring, MD 20902 Louise Cohen/Sister-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) iffit Orc Date 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Department Important II any injury or Mt. Lebanon Cemetery 08/01/2011 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June of Service Licer 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M0124 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Lung Cancer with Bone Metastases disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Weeks S quentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury Acute Renal Failure Week and that initiated events resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown Year ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Dementia 1X Yes 2 No 3 Probably 4 Unknown Completed Old Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 ANO After this certificate Malignant Pleural Effusions 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 07/30 12011 D0065485 Supanich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 1500 Forest Glen Road, Silver Spring, Maryland 20910

RSM, MD,

Barbara Supanich,
B1. Date filed (Month, Day, Year)

AUG 01 2011

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				1. Decedent's Name	e (First, Middle, L	ast)								2. Date of De	eath			3. Time of Death
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		Examir	ıer	4a. Facility Name (if	_		nber)			4b. City, To			f Death			c. County		
		Funeral		Suburban 5. Social Security No			7. Age (In	vrs. last	birthdav)	Beth		If Under 2	24 Hrs.	8. Date of Bi	rth		omery	lace (State or Foreign
		Director		218-54-88	846	Sex 1 X M 2 □ F	61		Yrs.	Months	Days	Hours	Min.	Mar 09	^y 1 ^Y 93	0	Coug	T
		d now at		Usual Residence of 10a. State	Decedent 10b. County		10	le City T	own or Loc	ation							1	0d. Inside City Limits
		arylar sa-f st ified a	ecto	MD	Montgo	mery			ille	ation .								1 🗆 Yes 2 🖾 No
		the M	Funeral Director	10e. Street and Nun	nber					10f, Zip C					10g. (Citizen of	What Coun	try?
		h with 15 23a nust b	nera	13405 Par	rkland D	rive				208.		_			USA			
		r death rriten inerr		11. Marital Status	ied 2 🗌 Married	12. Was Dece	rces?	in U.S.		_			in? (Spe , Puerto l	cify Yes or No- Rican, etc.)	•	14. Rac	e - Americ ck, White, e te	an Indian, etc.
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	Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	l ly	19a. Informant's Na	me/Relationship Miriam C		moth	er	19b. Mailing	g Address (S	Street ar	nd Number	r or Rurai	Route Numbe	er, City o	or Town, S	State, Zip C	ode)
	e,	and 2 Health tem 2		20a. Method of Disp						sition (Name				ate			- City or To	wn State
	mo	Page 1 ent of nt: If i		1 Donation	Cremation 3	Removal from	State	cem	etery, cremi	atory`or othi tan C:	er place	etory	T. 1	30,			•	
	alti	ermit. F spartm sporta sporta iy inju				-			22. L'	Name and	Address	s of Facility			1 H	OMA	ria,	Virginia
1	Ω	8978	10	21. Signature of Puneral Service Library e 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. West Silver Spring, MD 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														ng, MD 2090
	V			23a. Part 1. Enter to shock, or hear Immediate Cause (I	t failure. List only	one cause on ea	ch line,		o not enter	the mode of	of dying	, such as c	ardiac o	respiratory ar	rest,			Approximate interval Between Onset and Death
		Medical		disease or condition resulting in death)		_ a	monia or as a cor		ce off:			-					_	Onset and Death I-2 weeks
3		Examiner		Carriada lle lint and	- ditions		•	•	,	Cell(Carc	inoma	a					yrs.
2		_ <u>.</u>	nine	Sequentially list con if any, leading to kin cause. Enter Under Cause (Disease or i	rigitions, recliate rlying	Days to (or as a cor	risaduari	hé oty:									
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i	BC	ne dea / the a ched f	ysic	1 Yes 2 Unknown] No	9 Unkr	nant at time lown	e or deat	in 5 🚨	Other (spec	cify)			The state of the s		1410		Duy 10ai
	P.O.	that the ned by edetar	by Physician/Med	Part II. Other signifi	icant conditions	contributing to d	eath but no	ot resultir	ng in the un	derlying cau	use give	n in Part I.		23e. Did to	obacco	use contr	ibute to the	e cause of death?
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Michael	ion	tendir leath. or: Af the ful	ifica	1 Ϫ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigation 6 ☐ Could not	on he				М ,	1 🗆 Y	′es 2 □ n	No					
Z.	Division of Vital Records,	or Att after d Direct in by	Certificate:	4 Homicide	determined	28e. Place	of Injury - / ng, etc. <i>(Sp</i>	At home, pecify)	, farm, stree	et, factory, o	ffice		2	8f. Location (S City or Tow			er or Rural I	Route Number,
1		To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1	Certifying Ph	ysician: To the be	est of my k	nowledg	e, death oc	cured at the	e time, c	date and pl	lace, and	due to the ca	use(s) a	nd manne	er as stated	l.
		the Ho nin 24 the Fu thete		(Check 2 only one) 3	Certifying Nu	niner: On the bas rse Practioner: 1	s of examir o the best	of my kno	d/or investig owledge, de	ation, in my ath occurred	opinion d at the t	, death occ time, date a	urred at t and place	he time, date a , and due to th	ind place e cause	e, and due (s) and ma	to the cau	se(s) and manner stated. ted.
				29b. Signature and ti		ΙΛ Λ					icense r				29d. Da	ate signed	(Month, D	ay, Year)
•		12		30. Name and addre		Completed caus	a of death	(Itam ??) (Type P-		117	798				1/29/	111	·
				(eigh &	MStew	- Rol		A (8P)	Santa	in On	Dod	Be	thes	day MI) 7	N. BOK	1	
		Stat	е	31. Date filed (Month	G 0.1 20°	3 Re	egistrar's S	ignature	Bar	del.								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 25939 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0938 M William Clipp, Jr. Shea1v 111a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year, Director 56 218-62-9193 1955 Maryland March Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral U.S.A. 21740 21 East Baltimore Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) never employed never employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Christina Fraley Shealy William Clipp, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a East Baltimore Street Hagerstown, MD 21740 Shealy W. Clipp, Sr./Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otf Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 08/04/2011 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem. Sharpsburg, Maryland 21. Signature of Funeral Service Line see 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ 不 MOCURIL miles Medical resulting in death) Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated average) Examine Due to (or as a consequence of): sician and burial-transit when s death certificate be executed The that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Stollenden 24a Was an Hospital or Attending Physician: The law page 2 performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JW-Z

within 2

AUG 0 3 2011 State Registrar

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ATTAG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

~ 0

29b. Signature and title of certifier

Redistrar's Signature

340

29c. License number

MILL ST

D 18019

29d. Date signed (Month, Day, Year)

HAGERSIOWN, MDZITYS

AUGUST 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25940 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\mathbf{July}^{\mathsf{Month}}$ Physician/ 2011 18 4:05 A^{M} Alan D. Cirker Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City The Johns Hopkins Hospital 8. Date of Birth
(Month, Day, Year)
April 20, 1943 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 □ F Months Hours New York 102-36-3976 Director 68 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State be notified at Director 1 Yes 2 X No Virginia Fairfax McLean 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must I United States 22101 724 Ridge Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Leonard Cirker Florence Markowitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) McLean, Virginia 22101 724 Ridge Dr. Susan R. Cirker / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State July 21, King David Memorial Gardens Falls Church, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 5755 Castlewellan Dr. Alexandria, VA 22315 Jefferson Funeral Chapel 23a. Pard . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 1 Der C'unaulable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury metastatic and -transit that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last attending physician I for use as the burial cal Physician/Medi 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year sate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

QCUTE MYDCARAIAL IN FACTION 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number completed cause of death (Item 23a) (Type, Print)

Box 68760

P.0.

State Registrar

FREDERICK MEYER, MD Christian . Regis ar's Signature 31. Date filed (Month, AUG 0 1

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	-	For State Registrar	State of Maryla		ertifica:			ivientai my	Reg. No	2011	25941
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Medic	al	CLAUDE EN S 4a. Facility Name (if not institution, give	DELAWTER		1 4b City	. Town or l	ocation of Death	AUGUS	11	. County of Deat	1203 PM
Examin	er	Α	RYLAND MEDICAL	CENT	1	BALTIF		11	40	CITY	tri
Funeral Director		5. Social Security Number 6. 214–34–2482	Sex 7. Age (In yrs 1 M 2 🗆 F	. last birthday		er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di June	av. Year)	Co	thplace (State or Foreign untry) cyland
aryland 3a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washing		City, Town or I							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
23a or 28 st be not	ral Dir	10e. Street and Number 9713 Driftwood L		9	10f. Z	ip Code .740			10g. Ci	tizen of What Co	ountry?
or items ; miner mus	by Funeral	11. Marital Status 1 □ Never Married 2 【X Married	12. Was Decedent Ever in L	J.S. 13	B. Was Dece If Yes, spe	edent of His ecify Cuban	, Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit	
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and 2 Health em 27 ther tr		Wilma L. Payne 20a. Method of Disposition	(Wife)	9713 Place of Dis			Lane H	agersto			
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- 5		30. Name and address of person who	^			5 B	HTIMARE	E MARYZ	LANDA	2120	0/
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/Medic Examin		4a. Facility Name (If not institution, g	PKINS HOSPI	ital	Baltin	r Location of Death	ity	4c. County of Balti	Death more
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20 = 20		art 1. Enter the beease, or co	mil			s Hwy.,			Um Approximate
ate be executed / Medical Examiner	lical Examiner	shock, or heart ail. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Λ . Λ	nsequence of): Stinal B	Distress leed	s Synda	me		Initerval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the burial director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of produced in the second of the second in the second of the second in the second of the second in the second of the sec	Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	су		23d. Date Mont	· ·
ires that signed by	by Ph	Part II. Other significant conditions	s contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
w requ	Completed by						24a. Was		ere autopsy findings availeble
The la ate ha	Somp						auto perfe 1 □ Yes	ormed3/ de	or to completion of cause of ath? ⊒Yes 2 ⊒No
cian: sertific setor,	Be	25. Was case referred to medical examiner?	Mossitali		1011	26. Place of Dea	th (Check only	one)	
Physi r this ral dir	٦.	1 ☐ Yes 2 ☑ No 27. Manger of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	f 28c. Inju	rv at	T	how injury occurred	
nding tth. r; Afte e fune	ation	1 Natural 5 Pending 2 Accident investigat	(Month, Day, Yea	ar) Injury	Wor	rkí?]Yes 2 □ No			
l or Atte after dea Director	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, sti pecify)	eet, factory, office			(Street and Number wn, State)	or Rural Route Number,
e Hospita 124 hours e Funeral letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my kaminer: On the basis of exa- and manner stated.	/ knowledge, deat mination and/or ir	h occurred at the to	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and man , date and place, ar	ner as stated. d due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	,		29c. Licens			29d. Date signed	
		• //////	1		KES	5-000		July 22,	2011
2110		30. Name and address of person w		(Item 23a) (Type,	Print)	6001	Verth wi	Ifo St Ral	Himore MD, 2128;
Sta	tę	31. Date filed Month Day, 1940	2011 Hayes 32 Registrar's S	Signature	a. V. j	0001	TO THE YOU	11 ()) 001	THINKING MILY, ZIGO
Registr		JUL 43	- June	Signature	ave				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 2011 9:37 Almeada Everett Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Cheverly Prince Georges Prince Georges Community Hospital 8. Date of Birth (Month, Day, Year) 12/20/1945 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖾 F North Days Hours Min. 65^{Yrs.} **Director** Carolina <u> 230-56-1517</u> Usual Residence of Decedent 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director or 28a-f sl notified 1X Yes 2 ☐ No Como NC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 27818 802 Boones Bridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government it. Page 1 and 2 should be filed with them of Health and Mental Hygien reant: If item 27 is marked other 1 njury or other traumatic event, the 8 Maintenance Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Roxie Cooper Ernest Elijah Everett 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3407 Dodge Park Road Apt. 201 Landover, MD 20785 Penny Everette - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Lincoln Cemetery 08/04/2011 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Brentwood, MD 20722 3401 Bladensburg Road 23a. Part 1. Enter the disease, ot complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ARRHYTHMIA CARDIAC FATAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No Yes 2 🔽 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural
2 Accid 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 2 29b. Signature and title of

CR

State Registrar

Registrar
DHMH 17 Rev 7/2009

3001 HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDHI SATTARIAN

31. Date filed (Month, Day, Year,

AUG 0 2 2011

29c. License number

DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25944 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 27, 3:45 P Charles Monroe Edens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5808 Thompson Road Silver Spring Montgomery 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 🗆 F Mir Octonth, Pay, 226-38-1384 Director 77 Yrs Virginia Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 15808 Thompson Road 20905 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Syes 2 No 1954—
If fes, Give
Year or Dates. 1956 Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other tl U. S. Government Computer Lab. Supervisor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Nannie Etta Collier Frank Edens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen J. Edens/ wife 15808 Thompson Road, Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 7/29/2011 Alexandria, Virginia Metropolitan Crematory 21. Sign ture of fur eral Service Ligensee 22. Name and Address of Facility Muriel H. Barber Funeral Home ot norten 470 Box 5038 Laytonsville, MD 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events and -trar resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Great Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the hed t Unknown ed by the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þγ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an r this certificate has be aral director, page 2 s autopsy perforn death? 2 🗌 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 37142 7-28-2011 levo

Registrar

541

State

Suite #100, Rockville, MD 20850

1355 Piccard Dr.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Geoffrey Coleman,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Esham Month-Ellen Gravenor Grace Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death REMONAL COMICO TONINSULA 845649 1 Year If Under 24 Ars. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country)
Maryland 1 🗆 M 2 🗶 F Mir 214-16-4411 01/05/1919 Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗷 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 201 Atlantic Ave. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 X Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Domestic traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Miller Herman Gravenor Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13333 Hatchery Rd., Bishopville, MD 21813 19a. Informant's Name/Relationship (Type, Print) Lye 1 and 2 s.

Lepartment of Health at.

Important: If item 27 is r.

any injury or other:

once. Vicki Daisey/daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 7/26/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 21. Signature of Funeral Service Licensee 22 Horloways Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Congestio Medical resulting in death) **Examiner** Sequentially list conditions, sequence of): cause. Enter Underlying Cause (Disease or iinjury Due to for as a c -transit certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mon Pregnant at time of death 2 No signed by the a d be detached f a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsv performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical pleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

Registrar

TECNANDO

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 25946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2022 M Atley Dwight Eaton Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Washington 4b. City, Town, or Location of Death **Examiner** Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex (In yrs. last birthday) 83 Yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 232-32-5169 Hours SWYTY) 1 🛣 M 2 🗆 F 9 - 2 9 - 1 9 2 7 **Director** Usual Residence of Decedent show 10c. City, Town or Location Hagerstown, 10a. State 10b. County Examiner must be notified at 10d. Inside City Limits Director MD Washington 28a-f 1 X Yes 2 □ No 0 10f. Zip Code 10g. Citizen of What Country? 14215 Maugansville Road items 23a Funeral 21740 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 □XYes 2 □ No 1945 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ ō 1 Never Married 2 K Married white 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Completed 1947 Year or Dates. traumatic event, the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) dairy farm Elementary/Seconday (0-12) College (1-4 or 5+) Farmer 12th grade and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last)
Velvet Eaton 18. Mother's Name (First, Middle, Maiden Surname) Ferris Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 Carlene A. Eaton wife 14215 Maugansville Rd. Hagerstown, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkhead Cem. 20c. Location - City or Town, State Department of H Important: If ite 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Big Pool, MD Ž011 ²² Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service L BOX 310 Clear Spring, MD 21722
de of dying, such as cardiac or respiratory rrest,
Approxim 23a. Part 1. Letter the disease, or comilications to it caused the death. Do not enter the shock, in heart failure. List only one cause in each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Yes 2 No 1 | Yes 2 L 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 IUNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 ☐ No was case referred to examiner? funeral director. Be 26. Place of Death (Check only one) 2 12 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

1116

trar's Signature

Medical Campus Road

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michae

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:30 PM 201 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MEMORIA HARFORD 20 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2**X**F PENNSHLVANIA 197-34-315 may 6,1944 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State if item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Madical Examination to notified at RISING SUN 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.5-A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WAITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWAFE and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ATHRYN UR NOLL ဂ 19b. Mailing Address (Street and Number or Rural Rou e Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra RISINGSUN, MD MANIEL FEATHER STUNE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1363 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) **Physician** intra cerebra hemorrhage /Medical Due to (or as a consequence of): Examiner erebral Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2 No 3 ☐ Probably 4 ☐ Unknown tole, 1 🗌 Yes After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 1 ☐ Yes of Vital Hospital or Attending Physician; after death.

Director; After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 30, Name and address of person who completed cause of death (nem 23a) (Type, Print) 10 4 ve 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ICKI LEE GIIIII	п	1- For State Registrar	tate of Maryla		artment of ertificate of		nd Menta		201 Reg. No.	1 25948
Physic Medical Exam		1. Decedent's Name (First, Midd			· ··· - ·			2. Date of Dea	ath Day Year	3. Time of Death
YIEUICAI EXAII	IIIIEI	4a. Facility Name (if not institution		mber)	4	b. City, Town, o	or Location of D	July 28, 2 Death	2011 4c. County of Dea	
		4675 Dallas Place #1				Temple Hi			Prince Georg	
Funera Director		5. Social Security Number 176–38–9913	6. Sex	7. Age (In yrs. 62		If Under 1 Ye Months Da		Min	irth (MM/DD/YYYY) 9. E Fore: 21, 1948	
Au A	İ	Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Location	on				10d. Inside City Limits
and f show	ا ة	Maryland Prin	ce George'	s Te	emple Hi	11s				1 X Yes 2 No
Maryl	Director	10e. Street and Number			,,,	10f. Zip Code	227/2		10g. Citizen of What Co	untry?
with the Maryland ns 23a or 28a-f sho be notified at once.	Z D	4675 Dallas P		dent Ever in L	J.S. 13. Was	Decedent of H	20748	(Specify Yes or N	USA o- 14. Race - Ame	erican Indian, Black,
death or item	Funeral	1 Never Married 2 M	Armed Fo	rces?				uerto Rican, etc.)	White, etc.	
rs after ural",	ě	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:			Yes 2X N		d of work done	Specify: B.	lack
5-0036 led within 72 hours after Hygiene. other than "natural",	Completed	Elementary/Secondary (0-12)			during mo	st of working life	e. DO NOT use		Private	Sili dustry
003(within giene.	dwo	17. Fether's Name (First, Middle	2		Denta	TI Hygie				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 71 is marked other than "natural", or items 23a or 23a-f she frammatic event, the Medical Examiner may be notified at once	BeC	Lee Rogers Gr						lame (First, Middle, 1yn A1exa	And the state of the state of the	
ID 21; should be and Men 7 is mar	2	19a. Informant's Name/Relations	1 ()1 /	a					mber, City or Town, Sta	
OFE, MD ges I and 2 sh of Health an if item 27 if		Jacqueline J. 20a. Method of Disposition	Fleming /	Sister	Place of Disposit			Date Date	e, MD 20720	
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and I Important: If item 27 is injury or other tranmatic		1 Burial 2 X Cremation		III Otato	crematory or other Metropolit		itory 8	/1/2011	Alexandria	a, Virginia
Baltimore permit. Pages I Department of I Important: If injury or other		4 Donation 5 Other Sp 21. Signature of Funeral Service			22. Na	ame and Addres	s of Fecility		4739 Balti	more Avenue
D RABE Physician		23a. Part VEnter the disease, or	CAL Posss	used the death					Hyattsvill	e, MD 20781 Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	on each line.			o mode of dying	, 3001 03 0010	ac or respiratory an	rest, shock, or heart	Between Onset and Death
Examiner	١.	or condition resulting in death)	Due to (or as a				_			
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a d	consequence o	of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence o	of):					
ecuted and transit			d		<u> </u>					
60, nte be executed hysician and e burial - transit	Medical	UNPENDED	AMENDED							
5876 rtificat ling phy	an/M	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	I I TIVE DI	th	2 Feta	I death 3	Ectopic pre	egnancy	23d. Date of delive Month	ry Day Year
Box 6876 The death certificate The attending phy The death of the attending phy The attending phy The attending phy The attending phy	Physician/N	1 Yes 2 No 9 Unk	4 ☐ Pregna nown 9 ☐ Unknov	nt at time of de vn	eath 5 Othe	er (Specify)			1	
P.O. Es that the digned by the detached		Part II. Other significant conditi			esulting in the un	derlying cause	given in Part I.		obacco use contribute to	
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COFC law red has be	ompleted			-				autop		completion of cause of
of Vital Records, g. Physician: The law require the this certificate has been sineral director, page 2 should b	ပ	25. Was case referred to medical				26 Place	of Death (Che	1 Yes	2 No 1 V	es 2 No
Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient				Residence 6 🗸 Othe	er; Scene
n of ding P h. After funera		27. Manner of Death 1 Natural 5 Pend	28a. Date of (Month, I Jul 28, 20	f Injury Day, Year) 111	28b. Time of Inj 0000 hrs	i	ry at Work? Yes 2 ✔ No	28d. Describe Subject stal	how injury occurred bbed	
Division tal or Attendi rs after death. al Director: /	ficati	2 Accident Inves	stigation		ome, farm, street,			28f. Location (Street and Number or R	ural Route Number, City
Div pital or ours aft ceral Di	Certification:	4 V Homicide deter	mined (Specify)	Home				or Town, S 4675 Dallas P	State) Place #102, Temple I	Hills, MD
Division of Vital Records, P.O. Box 68760, within a the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical			examination a					se(s) and manner as sta and place, and due to t	
	ž	29b. Signature and title of certifie				29c. Licens			29d. Date signed (Me	onth, Day, Year)
		30. Name and address of person	who completed cause	of death (Item	23a)	0.C.	IVI. C.		July 29, 2011	
12		Donna M. Vincenti, M.	Assistant Me	edical Exan	niner 900 V	V. Baltimore	Street, Ba	ltimore, MD 21	223	
S Regis	tate trar	AUG 0 2 2011	32. Regi	istrar' Signatu	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Ivial y		Certificate of L	Death	Re	g. No.	1	25949				
	Physicia		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day `	Year	3. Time of Death				
	/Medic			Robert Gome	\$			July	27, 2011 4c. County o		1646 M				
	Examin	er	4a. Facility Name (If not institution, give	ss Hospital			Location of Death		1	ontgon	neru				
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (Ir	yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	0 Di ii ii	e (State or Foreign Pakistan				
	D	_	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o						. Inside City Limits 1 □Yes 2 No				
:	ne Ma 18a-fs	Director	Maryland Montg	omery			Silver Sp		0g. Citizen of Wi	hat Country					
:	ath with the 23a or 2	ral Dir	10e. Street and Number 13209 Glen.			10f. Zip Code	20904			u.s.A	١.				
950	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a findice Examinar must be notified at once.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛛 No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:		Black Specify:		ian				
ה ה	72 hc	etec	15. Decedent's Ed (Specify only highest gra		1 ((ecedent's Usual Occup Give kind of work done	durina most of workir		16b. Kind of Bus	iness/Indus	itry				
7	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retired S 0	n Erver		Hosi	pitali	itu				
י כ	filed Hygi other ent, tr		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N							
0	ild be fental rked c	To Be	\mathcal{D}	aniel Gomes				Sabin	a Gomes						
a y	2 shou and N Is mai		19a. Informant's Name/Relationship (Type. Print)	I .	Mailing Address (Street									
	and 2 lealth m 27 her tr		Clara Gomes - Sp			09 Glenhill			ring, Mo 20c. Location - C						
	. Pages 1 ment of H tant: If Ite jury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		isposition (Name of crematory or other place Heaven Cel	$m. \frac{08}{02}$	2/2011 5	Silver S	pring	, MD				
Dan	permit Depart Import any in once.		21. Signature of Funeral Service Nicer	L MO16:		11800 New t	lampshire	Ave., S	ilver S	pring,					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
)	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Due to (or as a co											
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a co	onsequence of	:									
, , ,	ificate be executed physician and street the burial transit	ał Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	:									
00	rtificate ng phys as the	Aedical		d			8								
O. DOX	ath cel attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	су		23d. Date Mor	e of delivery nth Da	y Day Year				
us, r.	uires that the signed by do detact	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in t	he underlying cause giv	en in Part I.				cause of death?				
Records,	ding Physician: The law requires that the dr. n. further this certificate has been signed by the funeral director, page 2 should be detached	Completed			-			24a. Was a autops perfor	med? d	Vere autops orior to compleath?	sy findings available pletion of cause of				
מון	an: T tificat tor, pe	BeC	25. Was case referred to medical				26. Place of Death	1 □Yes n (Check only or			LINO				
>	nysici nis cer direc	일	examiner? 1 ∐ Yes 2 ∑ No	Hospital: 1 ☐ Inpatient	2 🗶 ER/Out	oatient 3 DOA Oth	ner: 4 \Bundaring Ho	me 5 ☐ Resid	ence 6 □Othe	er (Specify)					
5 1	ng Pł kiter tł ineral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	28b. Tii ear) Inj	ury Wor		28d. Describe h	ow injury occurre	∌d					
INISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After gompletely filled in by the funer	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 280 Place of Injury	- At home, farn Specify)	M]Yes 2□No	28f. Location (S City or Tow	treet and Numbe n, State)	ər or Rural F	Route Number,				
-	To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical Co	29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa	nysician: To the best of n miner: On the basis of ex and manner stated	amination and	death occurred at the ti or investigation, in my	ime, date and place, opinion, death occur	and due to the ored at the time, or	cause(s) and ma date and place, a	inner as sta and due to t	ited. the cause(s)				
	Vithin Somp	Me	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signed	i (Month, Da	ay, Year)				
B	4		1 to f			1	0055148		July 2	7, 20	11				
			30. Name and address of person who	completed cause of deat	h (Hom 23a) (T	vpe, Print)	0:0			00010					
	-01-		Delroy Anglin, M 31. Date filed (Month, Day, Year)	.D., 1500 F	orest (ken Koad,	silver Sp	rung, Ma	vrykand	20910					
	Sta Registr		AUG 01 201	Gender	A. A.	slen Road, .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 25950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Florence Ε. Guss 9:30 P. M Ju1y 27. 2ีซี 1 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Northampton Manor Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Sept 24, 1 🗆 M 2 🕱 F 028-20-9078 83 1927 Massachusetts Director Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Frederick Frederick Maryland XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21701 405 Culler Avenue Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) . Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own home 1 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Tina Stein** Mental ൧ Samuel Hasanovitz and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Culler Avenue, Frederick, Maryland 21701 Maurice Guss - husband f Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-29-2011 Frederick, Maryland 4 Donation 5 Other (Specify) Resthaven Memorial Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Camell 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each live Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) anding physician are as the burial Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2/5 No Month Day Year signed by the a 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, page 2 autopsy 2 No 1 Yes 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury a 28d. Describe how injury occurred injury 1 Natural Accider 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and 29c. License numbe

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of per

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25951 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hill 10:40p^M Joseph W. 2011 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 63 yrs If Under 1 Year **Funeral** (Month, Day, 1 X M 2 🗆 Months Days Hours Min. Yrs Windsor, N.C. **Director** <u>244-78-8663</u> May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am point on other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Funeral Director 1 4 Yes 2 No Maryland Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 11403 Mifflin Ct. 20744 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1★ Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer/ Retired Law Enforcement Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gladys Cherry Joseph Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Wife 11403 Mifflin Ct. Ft. Washington, Md. Mae Hill 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🕁 Removal from State Basemore Cemetery 8/03/2011 Windsor, N.C. 4 ☐ Donation 5 ☐ Other (Sp 22. Name and Address of Facility.
Alexander of Pope PA 5538 Mariboro Pike/ Forestville, Md. 20747 Signature of Funeral Service P. Enter the disk se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CAR disease or condition resulting in death) Due to (or as a consequence of): R Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Medical Certificate: To Be

To the Funeral Director: After this certific completed filled in by the funeral director,

that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of:				
rodding in dodiny Eddi	d					
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi	c pregnancy (specify)	3	23d. Date of delivery Month Day	Year
Part II. Other significant conditions	KONEY DISE	ASE ON			o use contribute to the cause of	
ATRIAL	FIBRILLATI	010		24a. Was an autopsy performed? 1 □ Yes 2		
25. Was case referred to medical			26. Place of Death (Che	eck only one)		
examiner? 1 ☐ Yes 2 X No	Hospital:	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inj	ury occurred	
3 Suicide 6 Could not 4 Homicide determined			ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Nun te)	nber,
(Check 2 Medical Exan	ysician: To the best of my know niner: On the basis of examinatio rse Practioner: To the best of m	n and/or investigation,	in my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and m	nanner state

10

within 24 hours a

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

State Registrar 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ MELUIN HART 7:26AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number Age (In yrs. last birthday) 64 Days Min. 1 XM 2 A F 578-58-4477 3²7-1947 Washington, DC Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Prince George's Temple Hills 1 🗓 Yes 2 🗌 No 10e. Street and Number Of. Zip Code 20748 10g. Citizen of What Country? 4412 Lyons Street United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Pepco d Mental Hygiene. marked other tha Laborer 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Hart Theresa Carter and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4412 Lyons Street Temple Hills, MD 20748 Health stem 27 i 4412 Lyons Street Barbara A. Hart (Sister) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Fort Lincoln Crematory 8/1/2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Solvice Licensee Brentwood, MD 20722 Kuhi Rd. 3401 Bladensburg Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CACHEXIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last UROSEDSI Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEWIA 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of HUPOXIA 24a. Was an autopsy performed? death? D18888 Yes 2 🖫 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 - No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Division of Vital Records, Director: /

State Registrar

SOUTHER and HOSPITA 31. Date filed (Month, Day, Year) Registrar's Signatu

determined

4 Homicide

only one) 29b. Signature and title of certifie

29a. Certifier (Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOO 64961

CENTUR 17503

DR WASEGNA

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

29d. Date signed (Month, Day, Year)

SURPATIS RUPA, CILNTON

			For State	State of I	Marylan		artment of F tificate of L	Health and N Death		iene eg. N 20	1 1	25953
			Registrar 1. Decedent's Name (First, Middle	, Last)		061	incate of L	Journ	2. Date of Death	h		3. Time of Death
	Physicia Medic		Fay Louise Harb						July 2	27, Day 201	1 ^{Year}	11:20 Ам
	Examin	er	4a. Facility Name (if not institution) 6097 Fountain I	_	r)			Location of Death		4c. County Fred	of Death erick	
ī	Funeral		5. Social Security Number		Age (In yrs. la		If Under 1 Year Months Days		8. Date of Birth	Year)	9. Birthp	place (State or Foreign
ı.	Director		220-34-1429 Usual Residence of Decedent	I I IVI 2 KRAF	73	Yrs.	Working Days		Aug. 31	, 1937 J	Mary	Yand
	yland •f shov ed at	ctor	10a. State 10b. County	a 4 - 1-		y, Town or Loc					1	0d. Inside City Limits
	or 28a- notifi	Director	Maryland Fred 10e. Street and Number	erick	F	rederi	10f. Zip Code		1	0g. Citizen of \	What Coun	1 ☐ Yes 2 🐼 No
	s 23a o	Funeral	6097 Fountain D	rive			217	02		United		-
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☒ Divorced	If Von Civo	s? X No	If		ispanic Origin? (Spe in, Mexican, Puerto Specify:			e - Americ ck, White, e	etc.
2-0	2 hour "natur	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced	ent's Usual Occup	ation during most of work	ing I	16b. Kind of B		
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Maryland 21215-0036	l be filed v lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, L Robert M. Castl					18. Mother's Name		laiden Surnam	9)	
_	d 2 should alth and M 1 27 is ma er traumat		19a. Informant's Name/Relationsh Carolyn Cable /					and Number or Rura Drive, F				Code)
Baltimore,	Page nent c ant; If ary or		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5		ate C	emetery, crem	sition (Name of natory or other place n Cremato		29 .	20c. Location	•	wn, State [aryland
Balt	permit. Departn Importa any Injt		21. Signature of uneral Service L	icentee		Re 9 5	Name and Address thaven 01 Catoo	Funeral S tin Mount	Services Lain Hwy	, Skkot Frede	Cody	y P.A , MĎ 21701
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	commications that cause on each	sed the death line.	h. Do not ente	r the mode of dyin	g, such as ca rdiac o	or respiratory arres	st,		Approximate Interval Between
1	Medical		Immediate Cause (Final disease or c dition resulting in death)	a	atic P		tic Canc	er			3	Onset and Death months
	≟xaminer	Ļ	Sequentially list conditions,	b. —								_
_	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	as a consequ	uence of):					- 5	
	certificate be executed nding physician and use as the burial-transit	I Exa	that initiated events resulting in death) Last	C. Due to (or a	as a consequ	uence of):						
09	ate be physici the bu	edical		d							+	
89	certific inding I use as	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			leas to a con-			23d. Da	te of delive	ery
O. Box	v requires that the death certific been signed by the attending I should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnan 9 Unknow	nt at time of c		Ectopic pregnand Other (specify)	:y	1	Mc	onth	Day Year
JS, P.C	law requires that the nas been signed by the s 2 should be detach	by	Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
Division of Vital Records,	sician; The law rec s certificate has bee lirector, page 2 sho	Completed							24a. Was ar autops perform 1 \sum Yes 2	y ned?	Were autor prior to cor death? 1 Yes	osy findings available mpletion of cause of
Ta Ta	ician; Tertifica	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Check		- Lagar (10)		
<u> </u>	y Physic er this c eral dir	e: To	1 Yes 2 X No 27. Manner of Death	1 ☐ Inp 28a. Date of i	njury	ER/Outpatien 28b. Time of	28c. Injury	4 □ Nursing Ho y at	ome 5 🛭 Reside 28d. Describe ho)
ono	ending eath. or: Afte he fun	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	Day, Year)	injury	M 1 🗆	? Yes 2 🗆 No		. ,		
JIVIS	al or Att s after d I Direct d in by t		4 Homicide determ	iped 28e. Place of	Injury - At ho etc. (Specify		et, factory, office		28f. Location (Str City or Town,		er or Rural	Route Number,
	To the Hospital or Attending Physician: "In the Funeral Director, After this certification and the Funeral Director, After this certification and the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the function of th	Medical	(Check 2 Medical E	Physician: To the best ixaminer: On the basis of Nurse Practioner: To the second of the basis of Nurse Practioner: To the basis of the	of examination	n and/or invest	gation, in my opinio	on, death occurred at	t the time, date and	d place, and du	e to the cau	use(s) and manner stated.
ø	To t To t		29b. Signature and title of certifier	1/2 n/m	MI	\supset	29c. License	number 48184		9d. Date signe		
	2		30. Name and address of person	•			rint)				.,	
	Stat	e	Elhamy D. Eskar 31. Date filed (Month, Day, Year)	32 Pools	501 W strar's Signat	TURA -		Frederick	, MD 21	.01		
	Registra		JUL 2	9 2011	rein	1. 14	barke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25954 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Physician/ Month Hilda Arline Hollenbaugh \mathbb{A}^{M} 1040 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington 10903 Clinton Avenue Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days Hours Min March 9,1925 Mary Tand Director 219-12-1790 86 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 10903 Clinton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖪 No 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes. Give 3 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Newspaper Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Wesley Shipley Edna Mae Showe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10903 Clinton Avenue Hagerstown, Maryland 21740 Harry P. Hollenbaugh (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park August 3,2011 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature i Funeral Scrvice Licensee 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as consequence of burialattending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 2 No Yes Hospital or Attending Physician: 24 hours after death. of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Division М Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Kendle alle

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25955 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 15 PM Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** sstown Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Jan. 12, 1928 Months Hours 199-16-0994 Pennsylvania Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Clear Spring Maryland Washington County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12457 Ashton Rd. 21722 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Catherine Arrison Jones Nelson Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen B. Hawkins, Jr. -son 12457 Ashton Rd. Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Paul's Cemetery 8-2-2011 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licenses 1331 Eastern Blvd. NOrth Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mentia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and the for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 Unknown 9 🗌 ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

Division of Vital

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		1	For State	State of Ma	aryland / L	-	ent of H ate of D				11	25956
			Registrar 1. Decedent's Name (First, Middle, Las	(t)		Certino	ale of D	eaur	2. Date of Dea	Reg. No 2 0		3. Time of Death
	Physicia Medic	n/ al	L	ena M. Iac	rangelo				July	28. 20		3:52a M
	Examin	er	4a. Facility Name (if not institution, give Aspenwood Sen]	4b. (Location of Death Lr Spring		4c. Coun	ty of Death Monto	gomery
	Funeral Director		5. Social Security Number 6. Sec. 579 – 30 – 4020	7. Age	e (In yrs. last birti 83	hday) If U Yrs. Mon	nder 1 Year ths Days	Hours Min.	8. Date of Birt	7928		place (State or Foreign Ungton, DC
	land show dat	l. I	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	he Mary or 28a-f s notifie	Funeral Director	Maryland Montg 10e. Street and Number	omery		10:	S.A. f. Zip Code	ilver Sp	ring	10g. Citizen o	f What Cour	1 ☐ Yes 2 🗷 No
	th with t ns 23a must be	ineral	3433 S. Leisure			las vii - 5		20906		1		S.A.
900	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	ह	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X if Yes, Give Year or Dates.		If Yes,	ecedent of His specify Cubar es 2 🗓 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ace - Americ ack, White, fy:	
21215-0036	s filed within 72 hour tal Hygiene. of other than "natu event, the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5		(Give kind o	Usual Occupa f work done di Tuse retired)	ition uring most of work	king	16b. Kind of		•
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Maryland	should be filed within 72 h and Mental Hygiene. 7 is marked other than "raumatic event, the Med	To Be		tonio Borz				18. Mother's Nan	Zena S	ambata	ro	
			19a. Informant's Name/Relationship (T) John M. Iacangel					nd Number or Rui S Drive,				
ore,	ge 1 and tof He if item or other		20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐			ry, crematory	or other place		Date 01/2011	20c. Location	-	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		4 ☐ Donation 5 ☐ Other (Specification of Funeral Solvice License)		_	22. Nam	ven Cen	s of Facility Hi	nes-Rino	ıldi Fu	neral	Home, Inc.
	407.0	\vdash	23a Part 1. Enter the disease, or compshock, or heart failure. List only o	plications that caused	the death. Do r			Hampshir g, such as cardiac			Spra	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Kan	crestic		·					Onset and Death
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	b L	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	a consequence o	of):						
_	be executed sician and burial test	ja	resulting in death) Last	·	a consequence	of):						
200	icate by phys	ledic		l d								
Box 68760	Attending Physicians: The law requires that the death certificate be sr death. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bu	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No g □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death		ppic pregnancy er (specify)	y 			Date of deliv	very Day Year
, P.O.	es that th signed by be detac	l by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting i	in the underly	ing cause giv	en in Part I.	23e. Did to	1		the cause of death?
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Rec	i: The lar icate har r, page 2	Com							1 Yes	2 No	death?	2 No
Vita	hysiciar nis certif I directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	ent 2 ER/Ou	utpatient 3	Othe	ace of Death <i>(Che</i> er: 4 \square Nursing F	ok only one)	dence 6 🗓 O	ther (Specif	y Assisted
on of	nding Pl ith. After the funera	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of inju (Month, Day	ry 28b. i	Time of njury M	28c. Injury work 1 🗆	rat ? Yes 2 □ No	28d. Describe h	ow injury occi	urred	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has lab appleted filled in by the funeral director, page 2 s	I Certificate:	3 Suicide 6 Could not b 4 Homicide determined			rm, street, fa	ctory, office		28f. Location (S City or Tov		nber or Rum	al Route Number,
	To the Hospital or within 24 hours affe To the Funeral Director Completed filled in I	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination and/o	or investigatio	n, in my opinio	n, death occurred	at the time, date a	ind place, and	due to the c	ause(s) and manner stated
	To the withing	2	29b. Signature and title of certifier	_ Mich	al Pist	Ivan	29c. License			29d. Date sign		Day, Year)
	•		30. Name and address of person who of Michael Pishvaia					-:-	hinaton	DC 20	0007	/
	Sta		31. Date filed (Month, Day, Year) AUG 01 201	2. Registra	ar's Signature	berte	<i>y</i> ,	,				
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Physician

/Medical

Examiner

Director

Funeral

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Funeral

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

e filed within 72 hours after If Hygiene. other than "natural", or ite

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 Is marked other any injury or other traumatic event,

Physician

Baltimore, Maryland 21215-0036

death with the Maryland

attending physician and for use as the burial-transi Box 68760. P.O. Division or Vital Records.

Certification: 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Ith Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 2 2011 Registrar DHMH 17 Rev 1/2001

105.85

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25958 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KYMINGHAM July 23, Day 2011 Year Pearl 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Montgomery Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 577-34-0762 1 □ M 2 □ X F Months Days Hours 1929 Harrisburg, PA Yrs Director May Usual Residence of Decedent or 28a-f show notified at 10c City, Town or Location Mary Tand 10d. Inside City Limits Montgomery Director 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be a 20832 Funeral 18409 Queen Elizabeth U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker home Be 17. Father's Name (First, Middle, Last)
Gilbert 18. Mother's Name (First, Middle, Maiden Surname) Smith ည Kasten Rebecca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2856 Rolling Fork Way, Glenwood, MD Elias Kymingham 20a. Method of Disposition 20b. Place of Disposition (Name of Norbeck Member 1917) Park July 26,2011 Olney, Maryland 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Hollie 21. Signature of Foner Pervice Licer 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Pelvic Fx Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and علم المجادة علم المجادة علم المجادة المجادة المجادة المجادة المجادة المجادة المجادة الم Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 12:30Р м July 16,2011 2 □**X**No 1 Yes **X**Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 10\$23781887 Rd., Potomac Village, 4 Homicide determined Restaurant Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO July 25, 2011 D71462 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Dan M. Danila, MD

AUG 0 1 2011

31. Date filed (Month, Day,

8600 Old Georgetown Rd., Bethesda, MD

			Sta	ite of Marylan	-			d Mental Hy	giene	1 1	25959
			Registrar		Cer	tificate of L	Death		Reg. No.		23333
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Milton U. H	Cessler				2. Date of De Month July	Day	Year	3. Time of Death 3:50 P M
	Examin		4a. Facility Name (if not institution, give street as	nd number)	_	4b. City, Town, or	r Location of De			ty of Death	7 3.30 1
			Hebrew Home of Greate	er Washing	ton	Rockvil	.1e		Мо	ntgome	ery
	Funeral		5. Social Security Number 6. Sex 1 X M 2	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 H Hours Mi		th	9. Birthp	lace (State or Foreign
	Director		3,0 20 JIJ2 A	88	Yrs.			in. (Month, Da May 9,	1923	Washi	Ington, DC
	nd how at	_	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation				1	0d. Inside City Limits
	aryla a-f s fied	ecto	MD Montgomery		thesda					- 1	1 🗆 Yes 2 😾 No
	or 28	ä	10e. Street and Number	Бе	thesua	10f. Zip Code			10g. Citizen o	f What Coun	
	with t	Funeral Director	7401 Westlake Terrace	#202		2081	7		United		
	eath tems er mu	Į.	11. Marital Status 12. Wa	Decedent Ever in U.S	S. 13. V			(Specify Yes or No- erto Rican, etc.)		ace - America	
0	ter d	þ	1 ☐ Never Married 2 💢 Married 📗 1 🖸	ned Forces? Yes 2 □ No				erto Rican, etc.)	В	ack, White, e	
9500-91212	ursat ural" II Exa	Completed	3 Widowed 4 Divorced If Y	es, Give ror Dates. WWII	1	Yes 2 X No	Specify:		Specia	fy: Whi	te
ζ	2 hor	ple	15. Decedent's Education (Specify only highest grade comp	oleted)		ent's Usual Occup		vorkina	16b. Kind of	Business Inc	dustry
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N	ed wil Hygie ther int, th	Be (17. Father's Name (First, Middle, Last)		Seli-	employed				quor	
yland	oe file	To	Jacob Kessler					Name (First, Middle,		ne)	
₹	ould Ind Me marl		19a. Informant's Name/Relationship (Type, Print	1	I tob Mailin	a Adduses (Ctuest	Sylvia	Rural Route Numbe	ole	Otata Zia O)(-)
Mar	12 sh ulth ar 27 is rtrau		Lois Kessler, wife	,				e, #202]	-		20817
saltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items Z3a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		Place of Dispos	sition (Name of		Date	20c. Location		
Ē	Page lent o nt; If ry or		1 X Burial 2 ☐ Cremation 3 X Remova 4 ☐ Donation 5 ☐ Other (Specify)	ii ii Oi ii Qiate		atory or other plac		21/2011	Follo (hanah	, Virginia
<u>=</u>	mit. F oartm oorta / inju		21. Sig atur of Funeral ervic-Lice see	KIII	22	. Name and Addres	ss of Facility 114	inoc-Pino	1dd Fun	nuren	Home, Inc.
ñ	o a L C		The the	MUDOTO	5 11	800 New	Hampshi	re Ave	Silver	Sprin	nome, inc.
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<u> </u>	ertifica ctor,		25. Was case referred to medical examiner?			26. Pla	ace of Death (Ch		L yac no		
5	nysic his ce	유	1 Yes 2 No Hospital:	1 Inpatient 2 I		3 DOA Othe	er: 4 🔀 Nursing	Home 5 Resid	dence 6 🗆 Ot	her (Specify)	
5 5	ing r	ate:	27. Manner of Death 28a. 1 ✓ Natural 5 ☐ Pending	Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occur	rred	
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2	or An after of Direct in by	Certificate	4 Homicide determined ^{28e.}	Place of Injury - At ho building, etc. (Specify,		et, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
ָנ	spiral iours reral filled		29a. Certifier 1 Certifying Physician: To	the best of my knowle	edge death o	ccured at the time	date and place	and due to the ca	use(s) and man	ner as stater	1
=	To the hospital or Attending Priysican: The law requires that the clearn certificate be executed within 24 hours affor clearn. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit	Medica	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	ne basis of examinatior	and/or investi	gation, in my opinio	n, death occurre	d at the time, date a	ind place, and d	ue to the cau	se(s) and manner stated.
-	withi To the comp		29b. Signature and title of certifier	,	-3-,-	29c. License			29d. Date sign		
	3+1		mira Furli			D001	0487	,	7-2	18-20	1
			30. Name and address of person who completed	I cause of death (Item	23a) (Type, Pr	rint)					
			Mina Fazli, MD	6121	Montr	ose Rd	Roc	Kville	MD 2	0850	
	State Registra	7	31. Date filed (Month, Day, Year) AUG 01 2011	cause of death (Item 6121 32. Registrar's Signat	park	1					

	State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. Time of Death												
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			Kline Hospice H	ouse			Mount	Airy			Fre	deri	ck
	Funeral		,	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Birt	h (Year)	9. Birth Cour	place (State or Foreign htryBurma
	Director		216-79-0756 Usual Residence of Decedent		38	Yrs.				Oct. I	, 1972	L	Burma
and	show Lat	5	10a. State 10b. County		10c. Ci	ty, Town or Loc	cation						10d. Inside City Limits
Mary	Ba-f	Director	Maryland Frede	rick		Frederi	lck						1 X Yes 2 ☐ No
the	a or 2 be no		10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?
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Pours Pours	natur ical B	ete	15. Deceden	's Education		16a. Deced	ent's Usual Occ	upation			16b. Kind of E	Business In	dustry
21215-0036 within 72 hours after	e. nan "l Med	Completed	(Specify only highes Elementary/Seconday (0-12)	1	1-4 or 5+)	life. DO	ind of work don DNOT use retire	d)	ost of work	ing			
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1 and	of Hea item other		20a. Method of Disposition		20b. l	Place of Dispos	sition (Name of		-	Date	20c. Location	- City or T	own, State
baltimore, permit. Page 1 and	nent o		1 Burial 2 ☐ Cremation Donation 5 ☐ Other (St	3 □ Removal fror ecifv)	n State M	Restha Restha	ven Ven Garden	lace)	July 2	27, 2011	Freder	ick.	Maryland
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th cer	attending ph I for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna Birth 2 Fet	al death 3		ıncy				ate of deliv	
e death	the at hed fo	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unk	gnant at time of nown	death 5 ∟	Other (specify)				IVI	onth	Day Year
at th	been signed by the should be detached		Part II. Other significant condition	s contributing to	death but not res	sulting in the ur	nderlying cause	given in Par	rt I.	23e. Did to	bacco use con	tribute to t	he cause of death?
J, J	signe d be	d by								1 🗆 '	Yes 2.₩ No	3 🗆 Pro	bably 4 🗆 Unknown
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an: T	nis certificate ha: Il director, page 2	Be C	25. Was case referred to medical	1			26.	Place of De	eath (Check	1 Yes	2 LXI NO	1 \(\text{Yes} \)	2 L NO
VIL	nis cer direc	70 E	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DOA O	ther:	Nursing Ho	me 5 🗆 Resid	ence 6 🔀 Oth	er (Specif	Hospice House
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or At	Direction by	Certificate	4 Homicide determin	28e. Place	e of Injury - At ho ing, etc. <i>(Specif</i>)		et, factory, office	Э		28f. Location (S City or Tow		er or Rura	I Route Number,
The Hospital of Attending Physician: The law requires that the death certificate be executed in the control of the Hospital of	within 24 hours after death. To the Funeral Director: Afte completed filled in by the fun		29a. Certifier 1 XX Certifying I	Physician: To the I	pest of my know	rledge, death o	ccured at the tin	ne, date and	d place, an	d due to the car	use(s) and man	ner as state	ed.
ne Ho	n 24 r ne Ful pletec	Medical	(Check 2 Medical Ex	aminer: On the ba	sis of examinatio	n and/or investi	gation, in my opi	nion, death	occurred at	the time, date a	nd place, and di	ie to the ca	use(s) and manner stated.
To th	To #		29b. Signature and title of certifier	h_~	1_			ise number			29d. Date signe	ed (Month,	Day, Year)
					I		DU	196	01		7/28	120	1 (
	4		30. Name and address of person w Sadaf Taimur, M	ho completed cau D. 46 B	e of death (Item Thomas	Johnso	rint)			ck, MD 2	21702		
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	9 201 32. F	Registrar's Signa	ture A.	parker						

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:37 A M Franklin Kercheval, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hagerstown Washington Meritus Medical Center Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov. 16, 1 X M 2 □ F Months Hours Min. Year 1923 Pennsylvania Director 203-10-6838 87 Usual Residence of Decedent 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20009 Rosebank Way #105 21742 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 No Specify. "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Aircraft (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Director of Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Franklin Kercheval Jane Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Pamela Ebersole/Daughter 14953 Secrist Rd., Mercersburg, PA 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or otl 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place. Donation 5 Other (Specify) 8/4/2011 Hagerstown, MD Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, aus , n each line . Approximate Interval Between Onset and Death Immediate Cause (Final Physician . rattor disease or condition Medical resulting in death) to (or as a consequence of): Examiner neumonus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or a ng physician a as the burial-1 Physician/Medical The law requires that the death certificate be P.O. Box 68760 attending yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate funeral director, page 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 PInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work within 24 hours after death.

To the Funeral Director. A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 5962 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July [™]2011 26, <u>Gwe</u>ndolen Knisley Р 3:19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Genesis of Waldorf</u> Charles Waldorf If Under 8. Date of Birth 7. Age (In yrs. last birthday) ear If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
915 Maryland **Funeral** (Month, Day, 1 □ M 2 X F Months Days Hours Min 213-10-9809 Director Yrs 95 Usual Residence of Decedent 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 921 Truro Lane 20601 USA within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Yes 2 X No Armed Fo Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 X Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mes U.S. Federal Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Secretary Government/ NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benedict Constance Montgomery Margaret Viola Rosalie Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lillia Hardy/ Sister</u> Truro Lane, Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pauls Episcopal Cem. 8/1/2011 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home mo1164 3035 Old Washington Rd. Wa<u>ldorf, MD.</u> 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Of the and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has the Funeral Director after this page 2 s perform Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar DLD LINE

completed cause of death (Item 23a) (Type, Print)

12070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05913 State of Maryland / Department of Health and Mental Hygiene Christopher Kelly 25963 201 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 2230 hrs CHRISTOPHER KELLY August 6, 2011 Medical Examiner 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Wicomico River Mechanicsville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Country) MD Director 593-86-4978 AUG.5,1987 1X XM 2 F 24 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County Oc. City, Town or Location 1 Yes 2 X XNo MD CHARLES WALDORF 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14755 POPLAR HILL ROAD 20601 U. S. A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 XXNever Married 2 Married 1 Yes Widowed If Yes, Give Year Yes 2XX No specify. Specify: WHITE Divorced ₫. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than 10 LABORER ASPHALT COMPANY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) the CHRISTOPHER EDWARD KELLY TONI LEE ADELMAN Be 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONI L. ADELMAN/MOTHER 14755 POPLAR HILL RD., WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition AUGÜŜT crematory or other place) Burial 2 XXCremation 3 Removal from State METRO.CREMATORY 13, 2011 ALEXANDRIA, 4 Donation 5 Other Specify 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service License M00641 5635 WASHINGTON AVE., LA PLATA, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Immediate Cause (Final disease a.Drowning Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): ner if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and AMENDED 23a, 27, 28a-f, per me, g919 9-21-11 sm **X** UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Dav 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 ✔ Other: Scene DOA

Death

Year

Division of Vital Records, F.O. Box 68760, Hospital or Atteoding Physiciae: '24 hours after death. Fuoeral Director: After this certificiely filled in by the funeral director; I To the Hospital of within 24 hours at To the Fuoeral D

Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural subject drowned 1 Yes 2 X No Pending fd 10:30 pm fd 8-6-11 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Wicomico River (Specify) Mechanicsville, Md. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie OCME O.C.M.E. August 7, 2011

of death (Item 23a)

r's Signature

Assistant Medical Examiner

32. Registra

Name and address of person who completed causi

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year)

Registrar

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 23a pt.II. per me. 9922 12-29-11 sm. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Porfirio Soriano Lopez 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Vactor 214×/5/42 Prince If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth 6. Sex **Funeral** 9/19574950 1 XM 2 D F Hours Min. 60 Mexico none Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Prince Georges Riverdale 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5412 Quesada Road 20737 Mexico within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Mexican White If Yes, Give Year or Dates Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Landscape Co. 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Agustin Soriano Manuela Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Soriano/Daughter 5412 Quesada Road Riverdale, Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sameter, crimetory or other play Cipal Cemetery dni 8/6/2<u>011</u> Puebla, Puebla, Mex. 4 ☐ Donation ゟ ☐ Other (Specify) PHTE和Pades RENALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Physician Complications disease or condition Medical resulting in death) Due to (or s a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a gensequence of P-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, Chronic Alcoholism 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examinera 1 Yes 2 No Hospital Other: မြ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1004 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [State
Registra AMEND#25 per MD, 8/1/11; EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician LORENA SORIE LONG 8:50 AM 28 07 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Wonths | Days | Hours | Min. | (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 31.1918 Lancaster. 203-07-0771 92 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? na 23a or 2 7308 Greentree Road 20817 United States death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify Specify: Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Kaufhold Maqdalena Kreil ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Lobato, Daughter 7308 Greentree Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 8/2/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementiq /Medical Due to (or as a consequence of): Examiner Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit Attending Physician: The law requires that the death certificate be executed Fairure 10 physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 4 Dunknown 3 Probably peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 0 1 2011

Pinky Sings.

pinky Sings

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

8218 Wisconsin Avenue Suite 305, Bethesda, Maryland 20814

29c. License number

00057458

29d. Date signed (Month, Day, Year)

7/28/11.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Mahlon Conrad Mueller 2:08 PM Medical July 29 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel Social Security Number **Funeral** If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 | F Months Days Hours Min 548-40-3374 Director 78 Dallas, February Oregon Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits must be notified Maryland Prince George's College Park 1 X Yes 2 No 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4613 Clemson Road 20740 USA death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS. 14. Race - American Indian, Armed Forces? "natural", or Completed by Page 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1953–1954 Year or Dates. 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Car Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Conrad Mueller Cleo Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Melnick / Wife 4613 Clemson Road, College Park, MD 20740 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) 8/1/2011 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility

4739 Baltimore Avenue
Gasch's Funeral Home, P.A. Hyattsville, MD 20781 FAR Royas Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Ventricular Fibrillation Medical Due to (or as a consequence of) Examiner Hyponatremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Chronic Obstructive Lung Disease physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical ul or Attending Physicians. The law requires that the death certificate be a after death.

Director: After this certificate has been signed by the attending physicia Cardiomyopathy P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Yes 2 X N 2 No 1 🔲 Yes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 X No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D41248 7/30/2011 4+1 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 7300 Van Dusen Road

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

AUG 0 2 2011

Laurel, MD 20707

George I. Okang, M.D. Laurel Regional Hospital,

32. Registrars Signa

1/28/11 00246 McKibben, Seanne He

		-	For State Registrar	State of Marylan		ırtment of H <i>tificate of D</i>			giene Reg. N2 0 1 1	25967
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Medic	al	Jeannette N. McKibbo 4a. Facility Name (if not institution, give stree					July	28. 2011	2:46 A M
	Examin		Shady Grove Adventi			4b. City, Town, or Rockville			4c. County of Deat	
	uneral irector		307-30-3270	2 X F 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day DeC . 22		hplace (State or Foreign untry) anola, MS
and	show d at	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits
Maryli	28a-f otifiec	irect	Maryland Montgomer	y Gait	thersbu	rg				1 ☐ Yes 2 🖄 No
n with the	ms 23a or 28a-f sho must be notified at	Funeral Director	10e. Street and Number 18724 Walker's Choi	ce Road Unit	£ 3	10f. Zip Code 20886			10g. Citizen of What Co United Stat	
nd 21215-0036 filed within 72 hours after death with the Maryland	", or ite	by	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 Å No If Yes, Give Year or Dates.	l If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian, e, etc. LCASÍAN
15-(n "nat Æedica	Completed	15. Decedent's Educat (Specify only highest grade o	ompleted)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	tion uring most of worki	ing	16b. Kind of Business	Industry
212 within	grene. er tha t, the N	Col	Elementary/Seconday (0-12)	College (1-4 or 5+)	House				Own Home	
land be filed	and wental hygiene. is marked other than "natural aumatic event, the Medical Ex	To Be	17. Father's Name (First, Middle, Last) James Andrew Norris				18. Mother's Name		,	
S 0 5	4.2		19a. Informant's Name/Relationship (Type, F Nancee Camuti, Frie		19b. Mailing P. 0 .	g Address (Street a. Box 1050	nd Number or Rura 6, Rockvi	al Route Number LLE, Ma	r, City or Town, State, Zin Uryland 2084	, Code) 19
imore Page 1 an	Department of near Important: If item 2 any injury or other once,		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	Place of Disposemetery, cremetery	sition (Name of atory or other place Leaven)	Date 5, 201	20c. Location - City or Silver Sp	
Balt permit.	Import any inj once,		21. Signatur of Funeral Service Chensee	M01102	22.	Name and Address	s of Facility Sin ille Pike	iple Tri L, Rocki	hute ville, Mary	Zand 20852
N N	vician/ Medical aminer		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one callmmediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of the to (or as a consequence of						Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate	hepatic	uence ofj.	ncepho	lopas	hy		
ecuted	sician and burial-tensi	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (of as a consequence	aeni	e Cir	rhosis	. र्	liver	
760 icate be ex	ohysician the buria	edical	d							
. Box 687	To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled 1 by the funeral director, page 2 should be detached for use as the burial-ways in the funeral director.	₹	in the past 12 months?	If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 🔲	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	ivery Day Year
S, P.O	signed by Id be deta	d by Pr	Part II. Other significant conditions contrib Oli abetes me	I to		nderlying cause give	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the s a er death.	te has beer age 2 shou	omplete						24a. Was a autop perfo	prior to	topsy findings available completion of cause of
tal F	ertifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Pla	ce of Death (Check		2 ANO TO THE	Z LINO
F Vit	this ce al dire	욘	1 Tyes 2 LYNo	1 Nnpatient 2			4 ☐ Nursing Ho		lence 6 Other (Spec	ify)
for of	: After e fur er	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Ra. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🔲	at ∕es 2 □ No	28d. Describe h	ow injury occurred	
Dirision all or Atter	Director d by the	Certifi	3 Suicide 6 Could not be	8e. Place of Injury - At ho building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,
Le Hospitz n 24 hours	ne Funera	Medical Certificate:	29a. Certifier (Check only one) 3 Certifying Physician 2 Medical Examiner: 0 Certifying Nurse Pra	Jn the basis of examination	n and/or investi	gation, in my opinior	n, death occurred at	the time, date a	nd place, and due to the (cause(s) and manner stated
To th	* E		29b. Signature and title of certifier	m D		29c. License			29d. Date signed (Monti	
		-	, , , , ,		220 (5 5		1162		July 28	12011
			Name and address of person who completion of the Santian MD	19129 Da	tors -	Drive C	erman-	town,	MD 208	74
F	Stat Registra	- I	AUG 01 2011	32 Registrar's Signat	. par	KI				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			
			1. Decedent's Name (First, Middle, Last)	rtificate of Death		2011 25968
	Physicia		Billy R.C. Marzette		2. Date of Death Month Da July 22, 2	3. Time of Death 10:40a M
	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	Lamin		National Naval Medical Center	Bethesda	1	ontgomery
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		550-58-3616		Sept. 26, 1	1942 Fresno, CA
	shov dat	ģ	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	28a-1	irec	MD Prince George's Cheltenh			1 Yes 2 No
	ith the	ral	10e. Street and Number 10204 LeFevre Drive	10f. Zip Code 20623		tizen of What Country?
	ems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	nited States 14. Race - American Indian,
ထ္ထ	fter de ', or it amine	þ	1 □ Never Married 2 ▼ Married Armed Forces?	f Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 X No Specify:	Rican, etc.)	Black, White, etc.
Š	ours a	Completed	Year or Dates. 1987			opeany.
7	72 h in "na Medic	mple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work O NOT use retired)	ing 16b. K	íind of Business Industry
212	within giene. er tha t, the N		Elementary/Seconday to-121 College (1-4 or 5+)	Supervisor	U.5	S. Army
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified a	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam Alversa	e (First, Middle, Malden	Surname)
3	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. of Health and Mental Hyglene. filem 27 is marked other than "natural", or items 23a or 28a-f show filem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	Sherman Marzette, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin			
Ma	12 sho alth an 27 is r trau		Tob. Mann	ng Address (Street and Number or Run 4 LeFevre Drive, (· · ·	
re,	1 and of Hea fitem		20a. Method of Disposition 20b. Place of Dispo	sition (Name of		ocation - City or Town, State
Ĕ	Page ment cant; it ant; it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	natory or other place) n National 09/20)/2011 Ar1:	ington, VA
Baltimore,	permit. Page 1 a Department of I Important, If it any injury or of		V V V V V V V V V V V V V V V V V V V	2. Name and Address of Facility Mc(400 Georgia Ave.,		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each life.			Approximate
~ [hysician/		Immediate Cause (Final disease or condition Metastatic Pancro	eatic Cancer		Interval Between Onset and Death
	Medical Examiner		Due to (or as a consequence of):			
		Je.	Sequentially list conditions, if any, leading to immediate b.			
	g g	amir	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.			
	e exection and in an and in an	dical Examiner	resulting in death) Last Due to (or as a consequence of):			
9	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-true	edic	d			
200	certific nding use as	Ž/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
XO RO	death he atte	Physician/M	in the past 12 months? 1 Yes 2 No 1 Live Birth 2 Fetal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
Д. О.	that the or ned by the detache	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	and out the annual street in Deut I	Fig. 500	
	res tha signed	d by	Transition of the significant conditions contributing to death but not resulting in the c	ndenying cause given in Fart i.		use contribute to the cause of death? No 3 Probably 4 Unknown
ğ	law requires nas been sign 2 should be	lete			24a. Was an	24b. Were autopsy findings available
Division of Vital Records,	has has	Completed			autopsy performed?	prior to completion of cause of death?
ā	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec	1 Yes 2 X No k only one)	o les 2 la No
$\bar{\mathbf{z}}$	Physic this ce al dire	၉	1 Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatier		ome 5 Residence 6	; ☐ Other (Specify)
0	ding F h. After funer	cate	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
<u> </u>	Aften er dear ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stri			d Number or Rural Route Number,
_	ital or irs afte al Dir led in		building, etc. (Specify)		City or Town, State)	1
	to the hospital or Attending Physician: When I have after death. To the Funeral Director. After this certification pleted filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investoring only one) 2 Medical Examiner: On the basis of examination and/or investoring Nurse Practioner: To the best of my knowledge, or the basis of examination and/or investoring Nurse Practioner: To the best of my knowledge, or the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and/or investoring Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examination and Nurse Practioner: To the basis of examina	tigation, in my opinion, death occurred a	the time, date and place	e, and due to the cause(s) and manner stated.
	7	2	29b. Signature and title of certifier	29c. License number VIRG	INIA 29d. Dat	te signed (Month, Day, Year)
	5		1 X. Jan	0101058113		29, 2011
_			30. Name and address of person who completed cause of death (Item 23a) (Type, F Sam Wanko, M.D.		Naval Medi , MD 20889-	
	Stat Registra		31, Date filed (Month, Day, Year) AUG 01 2011 22. Registrar's Signiture	مه		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:07A M Martin Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Julia Marson Health Case C Hoberestown Washington enter 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral (Month, Day, Yea 1 □ M 2 🗶 F Days Director Ĩ917 214-09-4463 94 Hagerstown. MD Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 333 Mill Street 21740 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Air Craft Manufacturer 12 th Mail Room Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of any injury or other traumation မ Harry Martin Chanev Bertha Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 19706 Jefferson Blvd., Hagerstown, MD</u> 21742 Susan M. Hatfield / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 08/08/2011 | Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Htharogoleroti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit mabra that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy]Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗷 No 2 NO 1 🗌 Yes funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one, Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. 1 Natural 5 Pending Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) on who completed cause of death (Item 23a) (Type, Print) 333 Mill Street, Haver stown, MD 21740 TIN+ Z

Registrar DHMH 17 Rev 7/2009

State

Physician Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

		Please	Type or Pri									gible	e.		
	For State		State of Ma	arylan		artment of H rtificate of L					~ ~	1	1	250	חדם
	Registrar 1. Decedent's Name	e (First, Middle, La	est)			illicate of L	Jeali		2. Date of Dea	Reg. N	امک ل			3. Time of	Death
/	Charles	,,	Richard			Miller			Month August	Î	ay .	20^{Yea}	ĺ	4:15	
r		. 0	e street and number) Court #604			4b. City, Town, or Hagerst		n of Death		4	c. Coun	ty of De shir		on	
4	5. Social Security No	umber 6.5	Sex 7. Age	e (In yrs. la	st birthday)	If Under 1 Year	If Und	er 24 Hrs.	8. Date of Birt	h		9. F	3irthpl	lace (State o	r Foreign
	218-50-49 Usual Residence of	69	1 X M 2 □ F	62	Yrs.	Months Days	Hours	Min.	Dec. 15	y, Year)	948	Ì	Mar	yland	
ector	10a. State	10b. County		10c. City	, Town or Lo	ocation							10	Od. Inside Ci	•
JIrec	MD 10e. Street and Nun	Washing	ton	На	gersto	10f. Zip Code				100 0	Citizen o	f M/hat	Count		2 X No
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runerai	11. Marital Status	Jiiwood c	12. Was Decedent E Armed Forces?	Ever in U.S	6. 13.	Was Decedent of H If Yes, specify Cuba		Origin? (Spe	cify Yes or No-		14. Ra	ace - Ar	merica	an Indian,	
2	1 Never Marri	ied 2 X Married	1 ☐ Yes 2 🌠 If Yes, Give	No		1 ☐ Yes 2 🏋 No			r lloan, etc.)		Specia	ack, Wi			
erec	3 □ Widowed	15. Decedent's E	Year or Dates. Education		16a, Dece	dent's Usual Occup	ation			16b.	Kind of		√hi ssind		
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a					UCIL	ity Forem		Alia la Mana	- Mina Minada		nst		10	n	
0	17. Father's Name (Miller,							e (First, Middle, L. Knod		n Surnar	ne)			
	19a. Informant's Na				19b. Maili	ng Address (Street					or Town,	State,	Zip C	ode)	
	Susan Mi	ller Ker	sh/Wife		2021	7 Robinwo	od (Court	#604, H						742
	20a. Method of Disp		Removal from State	C	emetery, crei	osition (Name of matory or other place			Oate		Location Location			wn, State	
	21. Signator of Fai			12111	2 2	g Cremato 2. Name and Addre	ss of Fac	cility Re	st Have						
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		rt failure. List only (Final	nplications that caused one cause on each line a.	asta	utic	er the mode of dyir					ce	<u>^_</u>		Approxima Interval Bel Onset and	tween
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completed by									24a. Was autor perfo			o. Were prior death	to cor 1?	osy findings mpletion of	available cause of
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rilicate	1 Natural 2 Accident	5 Pending Investigation	(Month, Da		injury	wor			28d. Describe h	now inj	ury occu	ırrea			
Certili	3 Suicide 4 Homicide	6 Could not determined	be 28e Place of Init			reet, factory, office			28f. Location (S City or Tov			ber or	Rural	Route Num	ber,
меаісаі	(Check 2	Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	examination	and/or inves	stigation, in my opini	on, death	n occurred a	t the time, date a	and pla	ce, and o	due to t	he cau	use(s) and m	anner stated
	29b. Signature and	title of certifier	, and	•		29c. Licens	e numbe	95		29d. [Sate sign	$\frac{\partial}{\partial x}$	onth, I	Day, Year)	
	Yong	Tang, 1	completed cause of d	leath (Item		Print) Hoef	2157	forum.	, MAD	14	217	74	0		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ Anna 1250 DM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Harus S St. Hary's Nursina Leonardtown Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) 2-19-1915 1 □ M 2√ F 214-09-2432 96 Director Pool MD Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD St.Mary's Leonardtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21585 Peabody Street 20650 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates white 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) grocery store co-owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Pendleton Hovermale Lorena G. Ambrose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45892 Kristi Lynn Ct. Lexington Park MD Carole A.Spade daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Paul Cem. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-3-2011 Clear Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ng physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjun that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for Month Year Pregnant at time of death 1 Yes 2 Unknown ed by the a 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has t page 2 s performe 2 N Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: No No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 24 hours after death. Funeral Director: A 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0709 07 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21585 Peabody St. Leonardtown, MD 20650 Kirandeep

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG I

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05929 State of Maryland / Department of Health and Mental Hygiene Angela Nicole Mister 25972 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 7, 2011 2030 hrs **Medical Examiner** Nicole Mister Angela 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Baltimore** 1903 Aliceanna Street, Apt. B 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Maryland Hours Min. 02/23/1982 Months Days Director 212-04-6497 2 X F Usual Residence of Decedent 10d. Inside City Limits 107 10b. County 10c. City, Town or Location Huntingtown 1 Yes 2 X No Maryland Calvert Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she is other traumatic event, the Medical Examiner must be notified at once. Directo 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 20639 6205 Huntingtown Road Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes white 1 Yes 2 No specify: If Yes, Give Year Specify: Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fund Raising Consultant Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Debra Leigh Kiernan Gregory Dean Mister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ၉ Gregory D. Mister - father 6205 Huntingtown Rd. Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, August 12e 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Port Republic, Maryland Chesapeake Highlands Memorial Gardens Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Factor - Rausch Port Republic MD 20676 4405 Broomes Is. Approximate Interval 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medicul Death a. Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transil Physician/Medical AMENDED 23a, 27, 28a-f, per me, g918 8-17-11 sm X UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown this certificate has been signed by the at director, page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 Unknown pleted 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be Other₄ Nursing Home 5 Residence 6 Other: Scene Inpatient ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural Division 1 Yes 2 X No 5 Pending fd 8:20 pm fd 8-7-11 2 ___ Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1903 Aliceana St. Baltimore, Md. 3 6 X Could not be Suicide determined Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 8, 2011

State Registrar

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD 31. Date filed (Month, Day Year)

OCME

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of L			Reg. N 2 0 1 1	25973
			Decedent's Name (First, Middle)	, Last)				2. Date of Dea	ith	3. Time of Death
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	Examin	er	4a. Facility Name (if not institution,				r Location of Death		4c. County of De	
	Funeral		Southern Mary 1 5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	Clintor If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9. E	Birthplace (State or Foreign
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	anylar ka-fst ified	Director		e Georges	Clinton					1 X Yes 2 ☐ No
	or 28	١	10e. Street and Number		ļ	10f. Zip Code			10g. Citizen of What	Country?
	s 23a	Funeral	6411 Spring Bro	ook Lane		20735			United Sta	ates
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 🖾 Marri 3 ☐ Widowed 4 ☐ Divorced	If You Chie		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. 31ack
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ē,	and 2 s Health Item 27		20a. Method of Disposition	·	20b. Place of Dist	osition (Name of		Date	on MD 2073 20c. Location - City	
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Baltimore, Maryland 21215-0036	permit. Departir Departir Importa any inju	(Signature Funeral Service L	ichse)	M	22. Name and Addre	ess of Facility Jo	hn T. Rh	ines Fune	
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, s c. (Spec <i>ify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
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permit. Page 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/			,		-				Route Number					01756
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys M Exa To the Hospital or Attending Physician: The law "equires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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hysicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	3. Time of Death
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Examin	er 	Meritus Medical Cent	er		Hagers			4c. County of Wash:	ington
uneral rector		5. Social Security Number 220-52-1633 Usual Residence of Decedent	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Dec. 28	'ear)	9. Birthplace (State or Foreign Country) Maryland
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	1 Never Married 2 M Married 1 If Y	s Decedent Ever in led Forces? Yes 2 X No les, Give ar or Dates.	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	n, Mexican, Puerto			American Indian, White, etc. White
than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Seconday (0-12) Col		(Give	edent's Usual Occupa kind of work done o DO NOT use retired)		ing 1	6b. Kind of Busi	·
other ent, t	Be (17. Father's Name (First, Middle, Last)	0	по	usekeeper	18. Mother's Nam	ie (First, Middle, Ma		Hospital
rked tic ev	잍	Herbert Lee Andrews					Lorraine		
27 is ma r trauma		19a. Informant's Name/Relationship (Type, Prin Charles Edward Peppl	•	1	ing Address (Street a	and Number or Rura	al Route Number, C	ity or Town, Sta	
nt: If item y or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	20b al from State	o. Place of Disp cemetery, cre	osition (Name of matory or other place	e)	Date 2	0c. Location - C	ity or Town, State
Importa any inju once.		21. Signature of Femeral Service Licenses) (1) MALL	2	2. Name and Addres	ss of Facility Mi	nnich Fu	neral H	
sician/		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition		eath. Do not en		g, such as cardiac			Approximate Interval Between Onset and Death
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to the Funeral Director; After this ce, flicate has Leen signed by the attending physician and completed filled in by the funeral director, page 2 snould be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	es, outcome of preg Live Birth 2 For Pregnant at time of Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Monti	*
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this o	욘	1 Yes 2 Law Hospital 27. Manner of Death 28a	1 Impatient 2			4 L Nursing Ho	ome 5 🗌 Residen		(Specify)
or, After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Date of injury (Month, Day, Year)	28b, Time o injury	work		28d. Describe how	injury occurred	
al Direct led in by		4 Homicide determined 28e.	Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Stre City or Town, S		or Rural Route Number,
he Funer	Medical	29a. Certifier (Check 2 Medical Examiner: On the Check	he basis of examinat	tion and/or inves	stigation, in my opinio	n, death occurred at	the time, date and	place, and due to	the cause(s) and manner stated.
00 Con		29b. Signature and file of certifier	3		29c. License				Wonth, Day, Year) 4 2 nd, 2011
5		30. Name and address of person who complete	A, rus	1116	Print) Medica	l Carre	us Rd.	Hugu	Story, MO
Stat egistra		31. Date filed (Month, Day, Year) AUG 0 3 2011	32. Rėĝistrar's Sigr	nature powerpy and an	s. H.			Ü	
Rev 7/20	09	/	,	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25976 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 26, 201 Pay 8:35 p M Lorenzo F. Purvey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea January 21, **Funeral** 9. Birthplace (State or Foreign 1 XM 2 □ F Country, Director 219-72-3098 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Lothian 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1322 Marlboro Road 20711 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. 3 Widowed 4 Divorced Year or Dates Black permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professional Truck Driver Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McKinley Purvey Carlene Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1322 Marlboro Road, P.O. Box 145, Lothian, MD 20711 Renee S. Purvey - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Apostolic Faith Church Cem. July 30, 2011 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Owinas, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any course cause. Enter Underlying Cause (Disease or linjury Examine Que to for early displacements off To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Failux Completed I 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown Urinary tract Infection 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☐ No After this certificate I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 2 4 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Annapolis MD

use of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 25977 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eugene Edward Raedy 10:05 AM 29 July. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince George's 5902 Lockwood Road Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours (Month, Day, Yea 219-34-2630 73 Washington, DC Director 1938 January Usual Residence of Decedent fshow or 28a-f shov notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Prince George's Cheverly 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a o Funeral 20785 5902 Lockwood Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married X Yes ^{2 □ No} 1962 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction Dry Waller 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Francis Raedy Hilda Lingbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5902 Lockwood Road, Cheverly, MD 20785 Agnes M. Raedy / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 8/1/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Metastatic Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Parkinson's Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of Heart Disease 24a. Was an , has autopsy performed? Yes 2 No page 2 death? Dementia After this certificate 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending Accident Investigation safter death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Hospital 24 hours a Funeral L Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouatchou, MD Jocelyne 063748 8/1/2011 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Toukep Kouatchou, 201 East University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) State AUG 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0^{47} ^{nth} $27 - 2^{20}$ $\sqrt{11}$ 1:50 KAREN SCOTT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 N C Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 M 2 X F 0 8^{Month},1^{Day,} 1°°°,4 7 NCDirector 63 579-66-8438 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20032 1000 Congress St., SE er than "natural", or items the Medical Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗓 No چ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates Specify: Black 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 (al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Procurement Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o Department of Health and Mente Important: If item 27 is marked any injury or other traumations. မ Minnie Seabreeze Lee Alston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1000\ Congress\ St., SE, Washington,\ DC\ 20032$ 19a. Informant's Name/Relationship (Type, Print) Sheila Alsbrook/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lincoln Mem. Cem. 08-02-2011 1 XBurial 2 Cremation 3 Removal from State Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 20746 Signature Funeral Service Licensee Cedar Hill FH,4111 PA Ave.,Suitland, MD The three line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. . Part Enter the disease, shock, or heart failure. Li WKS . Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Wks. **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate characteristics. Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CVA with right hemiparesis in 2009 1 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CAD, COPD, HTN, Past history of lung cancer, 24a. Was an has autopsy lifelong cigarette smoker 1 Yes 2 Wo Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of al or Attending P s after death. Il Director; After th 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CR 5

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

upunich

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Supanich,

31. Date filed (Month, Day, Year)

AUG 0 2 2011

D0065485

20910

RSM MD,1500 Forest Glen Rd., Silver Spring,

			For State	State of Ma	aryland .					and M	ental Hy	giene	וור	25979
			Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate	e of D	eatn			Reg. No	Jii	
	Physicia Medic		Alta Lee Ste	arns							2. Date of Dea	Day 25	Year 2011	3. Time of Death 22.45 M
	Examin		4a. Facility Name (if not institution, give stre	eet and number)		1. 1	4b. City,	Town, or	Location o	f Death			nty of Death	
	-	П		eneral	Husp			nei		71)		onteg	
	Funeral Director		5. Social Security Number 6. Sex 051-24-5520	7. Age	e (In yrs. last l 88	birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt July 23			nplace (State or Foreign ntry) MO
			Usual Residence of Decedent								July 25	, 1723		
	yland f sho ed at	햕	10a. State 10b. County		10c. City, To	own or Loc	cation							10d. Inside City Limits
	e Mar r 28a- notifi	Director	MD Montgome	ry		Sano	dy Sp			_				1 Yes 2 No
	lid be filed within 72 hours after death with the Maryland Mental Hygiene. Heartal Hygiene. It was said to stems 23a or 28a-f show arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at	ral	10e. Street and Number 18100 Slade Schoo	1 Road			10f. Zip		860			10g. Citizen	of What Cou	intry?
	ems	Funeral		. Was Decedent E	ver in U.S.	13. V	Vas Deced	dent of His	spanic Orig	jin? (Spe	cify Yes or No-		lace - Amer	ican Indian,
9	fter de , or it amine	2	1 Never Married 2 Married	Armed Forces?	No		Yes, spec			, Puerto F	Rican, etc.)		Black, White cify: Whit	
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<u>S</u>	ld be Menta arked atic e	욘	Harry Edmond Grob,	Sr.					A1t	a Eu	nice Hu	ighes		
Maryland	2 should by Ith and Mer 27 is mark traumatic	Į.,	19a. Informant's Name/Relationship (Type, David M. Grob/Nephe								Route Number			
	and Heal em		20a. Method of Disposition		20b. Place	e of Dispos	sition (Nan	ne of				20c. Location		
Baltimore,	. 0		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metro	etery, crem			e torv	J u1 y ^D 20	11^{29}	Alexar	ndria.	VA
Saltı	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	1-1-		F2	Name an	d Addres	s of Facility	ins	Funeral	Ноте	Inc.	
ш	ŭ.□ <u>= @ o</u> ;		Joseph F.	195 1									Sprin	g, MD 20901
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	executed an and rial-transi	Exan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a	Consequence	e off:	nce	Me	_ 10	put	my		-	
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3/60	ificate g phy as the	Medi	LE ESTATE		- Interest									
λ Χ Ο Χ	r use	an/l	200. Was decedent pregnant	If yes, outcome		eath 3 🗆	Ectopic p	oregnancy	,				Date of deli	
X Q	e deat the att hed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (sp						Month	Day Year
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S,	uires t n sign	ed by	Dementia,								1 🗆 '	Yes 2 N	o 3 🗆 Pr	obably 4 Unknown
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ם ם	ding th. After funer	cate	1 Alatural 5 Pending 2 Accident Investigation	(Month, Day		injury	M Z	work?	Yes 2		8d. Describe h	ow injury occ	urrea	
DIVISION OF VITAL RECORDS,	· Atter er dea rector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	iry - At home,	farm, stre	et, factory	, office		2			mber or Run	al Route Number,
2	inital or urs aft ral Dir lled in									· ·	City or Tow			•
	Hosp 24 hor Fune eted fi	Medical		On the basis of ex	kamination and	d/or investi	igation, in r	my opinior	n, death oc	curred at	the time, date a	nd place, and	due to the c	ause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	2	only one) 3 Certifying Nurse P 29b. Signature and title of certifier	ractioner: 10 the l	pasi oi my kuc	zweuge, a		. License		and place		29d. Date sig		
	1741		· my						908			Jule	25	2011
	()		30. Name and address of person who com	pleted cause of de	eath (Item 23a	a) (Type, Pr	rint) 18.	111 I	rinc	e Ph	ilip Dr	ive, (lney,	MD 20832
	Stat	· 0	31. Date filed (Month, Day, Year)	32 Registro	r's Signature	M	onter	ome	my.	Oer	rend	Hlospi	tul	
	Stat Registra		AUG 01 2011	MA M J	A.	par	Ked.							

			State of Maryland / De	partment of Health and ertificate of Death		2011	25980
			Registrar 1. Decedent's Name (First, Middle, Last)	Fillicate of Death	2. Date of Death	eg. Né U	3. Time of Death
	Physicia Medic		Ann F. Scullen		July 29	Day 2011 Year	6:00 p ^M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	•
			Holy Cross Hospital	Silver Spring		Montgome	
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 \square F 7. Age (in yrs. last birthday rs. 1 \square M 2 \square F	Months Days Hours Min		Year 921 9. Birth	nplace (State or Foreign ntry) D.C.
			Usual Residence of Decedent		pee: 2.,		
	yland f sho	ţċ	10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
	e Mar r 28a- notifii	Director	MD Montgomery Silv	ver Spring	14	0g. Citizen of What Cou	1 Yes 2 No
	vith th 23a o st be		1102 Devere Drive	20903	"	USA	and y:
	tems	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ameri	
36	after d ", or i	by	1 Never Married 2- Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	to filean, etc.)	Black, White,	
Ö	atural	Completed	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Dec	cedent's Usual Occupation		16b. Kind of Business Ir	adustry
215	n 72 h an "n Medi	ldm	(Specify only highest grade completed) (Giv	re kind of work done during most of wo DO NOT use retired)	orking	TOD. KING OF BUSINESS II	ladeliy
21	l withi		12 Da	nce Instructor		Dancing	
Baltimore, Maryland 21215-0036	e filed ntal H ed otl	To Be	17. Father's Name (First, Middle, Last) George Edward Filgate		ame <i>(First, Middle, M</i> ann Tobin	laiden Surname)	
يَ	ould bud Me mark mark			illing Address (Street and Number or Ri		City or Town State Zio	Code)
Š	d 2 sh alth a n 27 is er trau			Devere Drive, Si			- 1
ore,	of He fiter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, cr	position (Name of rematory or other place)	8/4/11	20c. Location - City or 1	Town, State
<u>H</u>	. Page trnent tant: I jury o		4 □ Donation 5 □ Other (Specify) George W	ashington Cemetery		Adelphi, Ma	ryland
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		James a Lotter !	Francis Adress Collyins 500 University Bly	vd. W., S	ilver Sprin	g, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
44	Medical	1	Immediate Cause (Final disease or condition resulting in death) Acute Respiratory	Failure			Criset and Death
	Examiner		Due to (or as a consequence of): Sepsis				
		iner	Sequentially list conditions, if any, leading to immediate bases. Enter Underlying Due to (or as a consequence of):				
	outed und transit	Examiner	Cause (Disease or iinjury that initiated events c. Urinary Tract Info	ection			
	eath certificate be executed attending physician and for use as the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
1760	icate l g phys is the	ledio	d				
89 ×	n certif	an/N	IF FEMALE: 23b. Was decedent pregnant is the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of deli	
. Box 687	ne death the att	Physician/Me		Other (specify)		Month	Day Year
P.0	that the red by detace	by Pł	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tob	acco use contribute to	the cause of death?
ds,	quires en sigi vuld be	ted t	Chronic Atrial Fibrillation, Coagulo	pathy	1 ☐ Ye	es 2 No 3 Pro	obably 4 🔀 Unknown
COL	aw rec as be	Completed			24a. Was an	y prior to c	opsy findings available ompletion of cause of
Re	: The cate h				perform 1 Yes 2	ned? death?	2 🗆 No
/ital	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: I No 1 Inpatient 2 ER/Outpat	26. Place of Death (Che	, ,		6.1
of \	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	28d. Describe how	nce 6 Other (Special of the Communication of the Co	TY)
on	endin eath. or: Aft he fur	ficat	1 X Natural 5 ☐ Pending (Nomin, Day, Tear)	work? M 1 Yes 2 No			
Division of Vital Records, P.O.	lor Att after d Direct I in by I	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town,	reet and Number or Run , State)	al Route Number,
	To the Hospital or Attending Physician; The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, deat only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred	d at the time, date and	d place, and due to the c	ause(s) and manner stated.
	To the comp	-	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month	, Day, Year)
	15		Det M.D.	D68096		July 30, 20	11
_				len Road, Silver S	Spring, M	20910	
	Stat Registra		31. Date filed (Month, Day, Year) AUG 01 2011 32. Registrar's Signafure	gels.			

1-05775		Please Type or Print in Blac	k Indelib	le li	nk. Er	sure	All Co	pies	Are Le	gible			
urman Smith		State of Maryland / D	epartme	nt of	f Healt	n and	Menta	al Hyg	iene		20		2598
		l- For State Registrar	Certificat	te of	f Death	1			R	eg. No.	L 0		2030
Physicia	_	Decedent's Name (First, Middle, Last)						2.	Date of Dea	th		3	. Time of Death
ledical Exami	ner	Burman Hornine Smi	th						Month August 2,	Day 2011	Year		0807 hrs
		4a. Facility Name (if not institution, give street and number) 8507 Mapleville Road		1	4b. City, To		ocation of	Death			County of D		
Funeral		<u> </u>	yrs, last birtho	lay)	If Unde	1 Year	If Under :	24Hrs.	3. Date of Bir	th (MM/D	D/YYYY) 9). Birthr	place (State or
Director		217-09-9502 1XM 2 F	93		Months		Hours	Min.	Sept 1		Fo	oreign	try) Maryland
		Usual Residence of Decedent	93	Yrs	·				Sept 1		191/		"" Halyland
ku w			. City, Town or	Locat	ion							1	0d. Inside City Limits
E		Maryland Washington	Boonsb	orc									1 Yes 2 X No
Maryland 28a-f show dat ooce.	흸	10e. Street and Number	DOOLIGE	7010	10f. Zip	Code			1	0a. Citiz	en of What	Countr	v?
eath with the Maryland items 23n or 28n-f sho ust be notified at ooce.	Director	0507 M 1 111 D 1								-			•
ith th		8507 Mapleville Road 11. Marital Status 12. Was Decedent Eve	riniie L	13 \\/a		L713	anic Origin	2 (\$pec	ify Yes or No		S.A.	merica	n Indian, Black,
ath w	Funeral	1 Never Married 2 Married Armed Forces?		If Y	es, specify	Cuban, I	Mexican, P	uerto Ri	can, etc.)		White, et		ir iridian, black,
er de		1 X Yes 2 1	No 10/5	1	Yes 2	No.	specify:				Specify: W	Vhit	· e
ural'	<u>\$</u>	15. Decedent's Education (Specify only highest grade complete	1943 ted) 16a. De	ceden	nt's Usual C			nd of wor	k done		ind of Busine		
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	du		ost of work								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	힐	12	Eng	ine	er					R:	ailroa	ad	
d wil	팃	17. Father's Name (First, Middle, Last)	ביים	,		18	3.Mother's	Name (F	irst, Middle, I			* CL	
215 e file tal H	Be (George Washington Smith					Velli	e B	1anche	G G	rams		
21 Ould b		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing	g Address				al Route Nun			State, Z	ip Code)
MD d 2 shc Ith and n 27 is		Jeffrey L. Smith/Son	20	3 8	South	Sara	atoga	Str	eet Sa	alisl	bury,	MD	21804
C. Healt item	- 1	20a. Method of Disposition	20b. Place of	Dispos					ate		ocation - Cit		own, State
nort of other other	- 1	1 X Burial 2 Cremation 3 Removal from State		•		- 0 2611	<u></u>	0 / 0 5	/2011	Po	an ah ar		Maryland
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner, must be notified at once		4 Donation 5 Other Specify: 21. Signature of Funeral Survice Licensee	Boonsbo	22. N	lame and	Address o	of Facility	Bact	-Stauf	for	Funer	.0, ra1	Home, PA
Life Dep Des Constitution	- I	the contributed of							ke Boo				21713
Physician		23a. Part I. Enter the disease, or complications that caused the	death. Do not	enter t	he mode of	dying, su	uch as card	diac or re	spiratory arr	est, shoo	ck, or heart		Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Athel	rosclerotic (Cardi	iovascul	ar Dise	ase					8	Between Onset and Death
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Box 68760, e death certificate be extending physician deforms as the burial ed for use as the burial		3b. Was decedent pregnant in the past 12 months?	pregnancy 2	Fe	tal death	3	Ectopic p	regnanc	,		Month	Day	y Year
x 6 th cer trendi	77	Pregnant at time	of death 5	Ot	her (Speci	fy)							
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that the detached	by P	Part II. Other significant conditions contributing to death but	t not resulting i	n the u	underlying	ause giv	en in Part	l.					e cause of death?
Division of Vital Records, P.O. ral or Attendiog Physiciae: The law requires that it is after death. In Director: After this certificate has been signed by the funeral director, page 2 should be detaced.	ত	Left femur fracture, Congestive heart failure						_					oly 4 Unknown
ords, w requires to been a should	Completed								24a. Was autop				osy findings available inpletion of cause of
eco ne law te has	Ĕ					_	•		perfo	rmed? 2 ✔ No	deat	th? Yes	2 \ \ No
tal Re-		25. Was case referred to medical			2	6.Place o	f Death (C	heck onl	C	2 (*) 140	1 -	_ 100	
Vital Recc hysiciao: The la this certificate ha I director, page 2	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Out	atient	3 DE)A O	ther ₄ N	lursing }	fome 5	Residen	nce 6 🗸 C	Other: §	Scene
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ion tendio	ᅙ	1 Natural 5 Pending Jun 9, 2011	11301	าร		1 Ye	s 2 🗸 N	。 Sι	bject fell	while v	walking w	∕ith hi	s walker
isic	Sa	2 Accident Investigation 28e. Place of Injury	- At home, fam	n, stree	et, factory,	office bui	Iding, etc.	28	f. Location (Street an	nd Number o	or Rura	Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attendiog Physiciae: The law requires that the death certificate be enwithin 24 hours after death. To the Fuorral Director: After this certificate has been signed by the artending physiciar completely filled in by the funeral director, page 2 should be detached for use as the burial	Certification:	3 Suicide 6 Could not be determined (Specify) Assist	ed Living F	acility	y			85	or Town, S 07 Maplevii	itate) lle Road	d, Boonsbo	oro, M	D .
Hospi 4 hou Fuoer ely fil		29a. Certifier				ime, date	and place						
To the Hos within 24 h To the Fuc completely	Medical	one) 2 Medical Examiner: On the basis of examina											
To vit	ě	and manner stated. 29b. Signature and title of certifier			29c.	License	number			29d. D	ate signed	(Month), Day, Year)
		(m)				O.C.M	.E.			Augu	ust 3, 201	11	
		30. Name and address of person who completed cause of death	(Item 23a)										
TU-10		Donna M. Vincenti, MD Assistant Medical I		900	W. Balt	more S	Street, B	altimo	re, MD 21	223			

State 31. Date filed (Month, Day, Year) Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

cian/ dical	Decedent's Name (First, Midd Joanne	8/11/201 dle, Last) De1		ottlem	yer			2. Date of Deat Month August	th Day 1	2011		of Death 40 p ^M
niner	4a. Facility Name (if not institution	on, give street and r			4b. City, Town,					nty of Deat	th	
al	114 Catawba P. 5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	Hagers If Under 1 Year	r If Under 2		8. Date of Birth	<u> </u>		thplace (State	e or Foreig
or	217-32-7465 Usual Residence of Decedent	1 □ M 2 🔀	F 79	Yrs.	Months Days	Hours	Min.	$ \text{Mar}^{(Month, Day,} $, ^{Year)} 1932	_ Mar	yland	
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🚡	Maryland Wash	ington	Ha	gerstow	√n 10f. Zip Code				10g. Citizen o	of What C		∕es 2X N
Funeral	114 Catawba Pi	lace			21742				U.S.		; (
y Fun	11. Marital Status 1 □ Never Married 2 □ Mi	Armed	ecedent Ever in U.S Forces?		Was Decedent of I f Yes, specify Cub					Black, White		_
ted by	3 X Widowed 4 Divorce	ed If Yes, Year or	es 2 🛣 No Give r Dates.	1	∣ □ Yes 2 🛣 N	o Specify:			Spec	T.T1	hite	
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Con	Elementary/Seconday (0-12)		e (1-4 or 5+)	Homen						vn Hor	me	
To Be	17. Father's Name (First, Middle, Vernon John Go	. ,						First, Middle, N	/laiden Surna	ame)		
"	19a. Informant's Name/Relation	nship (Type, Print)			ng Address (Street	t and Number	or Rural R	Route Number,	City or Town	n, State, Zip		
	Robin Robin Robin			114 (Catawba :		Hager	cstown,	Maryl	Land	21742	
	20a. Method of Disposition 1 X Burial 2 Crematio 4 Donation 5 Other		rom State	emetery, crem	sition (Name of natory or other pla Cemeter		Dat		20c. Locatio			لمو
	4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	·· · · · · · · · · · · · · · · · · · ·	IROO		Cemeter Name and Address						Maryl 1 Home	
ol	23a David 5	WONG	ve/		506 01d					o, Ma		
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Registrar DHMH 17 Rev 7/2009

		•	1 - State of Maryland / State Registrar		tificate of De		rental Hyg	Reg. No. 201	25983
	Physicia Medic		Decedent's Name (First, Middle, Last) Donald Eugene STRAUB				2. Date of Dea Month July	30, 2011	3. Time of Death 15:50pM
	Examin		4a. Facility Name (if not institution, give street and number) 421 George Street		4b. City, Town, or Li Hagerst			4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 Sex 1 Sex 1 Sex 1 Sex 1 Sex 67	irthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 3	9. Bir 1, 1944 Ma	thplace (State or Foreign untry) Lryland
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov Maryland Washington Hag	wn or Loc erst					10d. Inside City Limits 1X Yes 2 □ No
	with the Ma 23a or 28 ist be noti	Funeral Dire	10e. Street and Number 421 George Street		10f. Zip Code	740		10g. Citizen of What Co	ountry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	lf	Vas Decedent of Hisp Yes, specify Cuban,	Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	thin 72 hour sne. than "natu ne Medical	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life. DC	ent's Usual Occupati kind of work done dur O NOT use retired) Stodian	ion ring most of work	ing	16b. Kind of Business	
and 2	e filed wit ntal Hygie ed other : event, th	To Be C	10 0 0 17. Father's Name (First, Middle, Last) Paul William Straub, Sr.			18. Mother's Nam		public scl Maiden Surname) Marie Bowe	
Mary	2 should the and Me 27 is mark traumatic		19a. Informant's Name/Relationship (Type, Print)	9b. Mailin			al Route Number,	City or Town, State, Zi	
Baltimore,	Page 1 and ment of Heal: ant: If item 2 ury or other		200 Method of Disposition	- 6 Di	sition (Name of natory or other place) n Memoria Park	- !	Date st 311	20c. Location - City or Hagerstown	Town, State
Balt	permit. Departr Imports any inji		21. Sign: Te of uneral Service Sicensee	22.	. Name and Address	of Facility		Funeral Heerstown, M	ome aryland 21740
	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause of shock line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Cost e afi: La	r the mode of dying, we have	such is cardiac of	or respiratory arre	gen dang	Approximate Interval Between Onset and Death
1760	icate be executed g physician and is the burial-transit	ledical	that initiated events c. Due to (or as a consequence d.	∍ of):					
. Box 68	ne death certifica / the attending p ched for use as t	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ls, P.O	law requires that the de nas been signed by the e 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting Vegus From	j in the ur	nderlying cause giver	n in Part I.	./	bacco use contribute to	o the cause of death?
Vital Records,	has has	Completed	Recliner Bro	ncl	ulis		24a. Was a autop perfor 1 Yes	sy prior to med? death?	topsy findings available completion of cause of
f Vital	Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate eted filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1	Outpatien	Other:	4 U Nursing Ho	k only one) ome 5 A Resid	ence 6 Other (Spec	cify)
Division of	r Attending er death. rector: Afte by the fune	Certificate;	1	injury farm, stre	M 1 ☐ Ye	es 2 🗆 No		treet and Number or Ru	ral Route Number,
ă	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and	or investi	igation, in my opinion,	death occurred a	d due to the cau the time, date ar	use(s) and manner as st nd place, and due to the	cause(s) and manner stated.
	To the within ? To the comple	Ž	only one) 3 Certifying Nurse Practioner: To the best of my known 29b. Signature and title of certifier	wledge, d	29c License n	umber	17	20d Data signed (Mont	h Day Yearl
	N-10		30. Name and address of person who completed cause of death (Item 23a) FRAN 288 A AN ORA) (Type, P. \$ 0€	rint) 353,	MICLS	T, Ape	SERSTORUM	·) MD2nxo
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 1	to all				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ рм Springfield Tuly 27th 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bowie Prince George's Springtime Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 5. Social Security Number 5 7 9 - 3 4 - 9 6 3 7 1 □ M 2 🗓 F (Month, Day, Year 1918 Maryland Months Days Hours Min. **Director** July Usual Residence of Decedent show 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Md Prince George's Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12506 Chalford Lane 20715 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 9 th College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jerimiah Ward Elizza Hawkens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 9313 Hobart Street Springdale, Maryland Calvin Jackson (Nephew) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) hington Nat Cem08/03/11 Suitland Maryland Signature of F 22. Name and Address of Facility DC 20011 Tyrone J. Young719 Kennedy StreetNW Wash 23a. Part 1 Enter the disease, or co shock or heart failure. List only plications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Polymicrobial Sepsis Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Dementia Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown the n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 No 1 Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) its.
//s after dea.
//s a Director. After ..
//s the funeral div 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by City or Town, State 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gartifying Nurse Fractioner: To the best of my knowledg 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 58182 July 30th 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C.Donald George M.D.7500 Hanover Parkway Greenhelt, MD 20770 31. Date filed (Month, Day, Year, 32. Registra State AUG 0 1 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 0 70nth 23-2011 4b. City, Town, or Location of Death 4c. County of Death

Funeral Director

441 State Registrar

Physician/ 3:30 P M THOMAS E. TOLLIVER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Days Hours 1 XM 2 AF 578-22-4056 85 06-Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 901 Arcola Avenue within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 X Married ò Maryland 21215-0036 If Yes, Give 1944-46 Year or Dates 1944-46 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) olice Officer Dist. of Columbia 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marken any injury or net. Thomas E. Tolliver Mary Gaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Larkspur Ln., Wake Village, TX 75501 Phillip N. Tolliver/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) D8-01-2011 Suitland, Maryland Cedar Hill Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility L. TISha Cedar Hill FH,4111 PA Ave., Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Years Priysiciai. Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Weeks Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical certificate be P.O. Box 68760 attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown Yes 2 No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hepatic Metastases, Splenic Metastases, To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' hours after death. neral Director: After this certificate I of filled in by the funeral director, page 2 X NO Yes 2 X 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, Suparich, RSM, MD D0065 485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, RSM MD, 1500 Forest Glen Rd., Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

AUG 0 2 2011

32. Registrar's Signature

			for State Registrar	State of Marylar		rtificate of			Reg. No.		23300
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of De Month	Day	/ Year	3. Time of Death
	/Medic	al	Berkley D. Willia					7-	28	2011	3:20 p M
	Examin	er	4a. Facility Name (If not institution, give	· ·			or Location of Deat	n		County of Death	
	Funeral	4	Sligo Creek Nursing 5. Social Security Number 6. Se		last birthday)	Takoma If Under 1 Year	If Under 24 Hrs	8. Date of Bir		ntgomery 9. Birthp	lace (State or Foreign
b	Director		578-09-3686	™ 2□ F	00 Yrs.	Months Days	Hours Min.	8. Date of Bir Month, Da 10-12	-191	0 Madi	son VA
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c Ci	y, Town or Lo	cation				1	0d. Inside City Limits
	Aaryla F sho	or	DC								1∐Yes 2 No
	the N	Director	10e. Street and Number	Wa	shingt	10f. Zip Code			10g. Cit	izen of What Cour	ntry?
	h with		1423 Roxanna Rd.	NW		20012			Uni	ted Stat	es
	deati	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No		14. Race - Americ Black, White,	an Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28e-f show eumetic event, the Medical Examples from the notified at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ₺ No		to ribari, oto.,		Specify: Bla	
2-0	72 ho netur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Occu	pation during most of wo	rking	16b. K	ind of Business/In	dustry
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О	filed v Hygie ther t int, It		12th 17. Father's Name (First, Middle, Last)		Maste	r Electr	T	me (First, Middle	4	ion Sumame)	
au	ld be ental ked o ic eve	To Be	Frank Williams					A. Gilfo		•	
ary	St. E. E. E.	-	19a. Informant's Name/Relationship (7	and Number or Ru			or Town, State, Zip	Code)			
	and 2 salth a 127 is		Almarine William	s/Wife	1423	Roxanna	Rd. NW W	ashingto	on D(20012	
ore	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumetic		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	semetery, crer	sition (Name of matory or other pla		Date		ocation - City or To	
Baltimore,	t. Pages tment of h tent: If ite		`4 ☐ Donation 5 ☐ Other (Specify	Che			ory 8-2			tsville	
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		21. Similar of Funeral Service I cen	e Comment			ess of Facility Jol Street 1				
U			28a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused the deal	h. Do not ent	er the mode of dy	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		mediate Cause (Final disease or condition resulting in death)	a. Failure To	Thrive						6 months
	/Medical Examiner		Tesoning in death)	Due to (or as a consec	uence of):						
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Ö,	e exe		resulting in death) Last	Due to (or as a consec	uence of):		•				
68760	ificate be executed g physician and as the burial-transit	edical		d							
-	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv		1			23d. Date of delive	any
Вох	death cert	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Ideath 3	Ectopic pregnand Other (specify)	ey			Month	Day Year
o.	that the de ned by the a	hysl	9 Unknown	9□ Unknown					Į		
s, P.	8 5 9	ру Р	Part II. Other significant conditions co		ulting in the u	nderlying cause g					he cause of death?
ord	w require been sig should t	Completed by	Chronic Kidney Di	sease			Diabetes	S 1 🗆	Yes 2	No 3 Prob	oabły 4 ∐Unknown
Division of Vital Records,	aw Is b	nple	Atrial Fibrillat	ion				24a. Was	DSV	24b. Were auto	ppsy findings available mpletion of cause of
西	Th ate pag		Stroke					1 ☐ Yes	ormed? 2 No	death?	2⊠ No
<u> </u>	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	LED/O	C:	han	ath (Check only		с Поль (Ольні	
ō	y Phys ar this eral di	27. Manner of Death	4 L Nursing F iry at ork?	28d. Describe		6 ☐Other (Special fry occurred	у)				
ol	ath. r: After	atio	1 ≅Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		rk?]Yes 2 □ No				
<u>S</u>	or Attend after death Director: / I in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str	eet, factory, office		28f. Location City or To		nd Number or Rura e)	al Route Number,
	orite oral		00-0-0-0					<u> </u>			
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier M Certifying Phyone) 2 Medical Exam	/sicien: To the best of my kno iner: On the basis of examina and manner stated.	ime, date and place opinion, death occi	e, and due to the urred at the time.	cause(s , date an) and manner as s d place, and due t	stated. the cause(s)		
	o the	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Da	te signed (Month,	Day, Year)
	->		Alle -			D286	556		Ju]	y 28, 20	11
	6		30. Name and address of person who o	completed cause of death (Iter	n 23a) (Type,	Print)				, ,	
	Ę.		Ravi Passe, MD. 1				ockville	MD 2085	0		
	Sta Begistr		31. Date filed (Month, Day, Year)	32. Registrars Signa	The Man						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 25987 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Walker Nathaniel 4:50 PM JULY 20 11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4250 Suitland Rd., Apt. 101 Suitland Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min 03-01-1922 246-16-6323 SC **Director** 89 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ΜD Suitland 1 Xyes 2 No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4250 Suitland, 20746 Rd., Apt. 101 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give 1 0 4 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Year or Date 1944 Specify: Black 3 M Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) $5\,t\,h$ College (1-4 or 5+) Private Industry Brick mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unav.) Arthur Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207464250 Suitland Rd., Apt. 101, Suitland, MD Roxine Thomas/granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Washington Natl. D7-30-2011|Suitland, Maryland 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death End-Stage Cardiomyopath Physi∟ian disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause (Disease). Due to (or as a consequence of) physician and s the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be as attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ĺ Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b performed Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗹 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760 Division of Vital Records,

3altimore, Maryland 21215-0036

1+1 State

31. Date filed (Month, Day, Year AUG 0 2 2011

29b. Signature and title of certifier

4 Homicide

29a. Certifier

Medical

determined

MSRAJapahnem O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakte, M.D 2835 Smith

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

20057465

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

7/29/11

		Registrar 1. Decedent's Name (First, Middle	State of N ns 23aPtI,II			tinoato oi z	3000		2. Date of De	eath			3. Time of	Death
Physici: Medi		Tonya Y. Wats	on						$\overset{ ext{Month}}{ ext{July}}$	2 7	20	rear	8:24	A
Exami		4a. Facility Name (if not institution				4b. City, Town, o		of Death			unty of			
	2	Prince George	-			Chever:						Geor		
uneral irector		5. Social Security Number 579-92-3823 Usual Residence of Decedent	6. Sex 1 □ M 2 🖾 F	age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi June 1	rth 6,1962	2	9. Birthplac Country	ce (State or DC	Fore
at	5	10a. State 10b. County		10c. City, T	Town or Lo	cation						10d	I. Inside Cit	y Lin
3a-f (tiffied	ect	DC		Wash	hingt	on							1 🏝 Yes	2 🗆
or 2 e no	ĪĒ	10e. Street and Number				10f. Zip Code				10g. Citizer	of Wh	at Country	/?	
s 23a ust b	Funeral Director	330 Ridge Road	, Southeast	#13		20019)			Unite	d S	tates	3	
ral nyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at		11. Marital Status 1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No			cify Yes or No Rican, etc.)	- 1	Black,	American White, etc		-
atura cal E	ete		Year or Dates.	1.5	16a. Deced	dent's Usual Occup	oation			16h Kind	of Busi	iness Indus	strv	
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arked arked tic e	<u>ئ</u>	James Raymond	Watson	_			Mary	Mic	key					
or neatin and Mentar is fitem 27 is marked o		19a. Informant's Name/Relations Margaret Ida Wa	1 1 21 7			ng Address (Street Kirtland								
Department of freat Important: If item 2 any injury or other once.		20a. Method of Disposition 1 □xBurial 2 □ Cremation 4 □ Donation 5 □ Other (\$		te Wash	ce of Disponetery, crem Lingto Ceme t	sition (Name of natory or other place on Nation	ial o) _{ate}	20c. Locat		•	n, State	
port port y inji		21. Signature of Funeral Service I	nsee			2. Name and Addre	ess of Facilit	y Pop	e Fune	ral Ho	mes	, P.A	Α.	
5 5 5		Trittelle	truce 791	1005	55	38 Mar1b	oro P	ike.	Fores	tville	, M	D 207	747	
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sician/ ledical			only one cause on each ling.	ne.	eve h	er the mode of dyin	ng, such as	cardiac o	r respiratory a			A	nterval Bety	veer
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistrAMEND@23a(a/b/c)perMD,8/1/11,BWI,McCCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ aroline E. Wood 651 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Anne Arundel County Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Year 927 Hours Feb. 23, 198-22-9876 Country) PA **Director** 84 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or item. 27 any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🌠 No Anne Arundel Annapolis 10e. Street and Number 10g Citizen of What Country? Funeral 1332 Swan Drive 21409 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Royall L. Marks Louise Kirschbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Laurence Wood/Son 1332 Swan Drive, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burlal 2 Cremation 3 Removal from State cemetery, crematory or other place, Aug. 2011 2, John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee rancis J. Collins Funeral Home Inc. 000 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Spiration pneumonia Approximate Interval Between Onset and Death -nysician/ disease or condition MEUMONTO Medical resulting in death) Bue to (or as a consequence of): Examiner spiration Sequentially list conditions, if any Making to immediate cause. Enter Underlying Examine for as a nonsconunce. If attending physician and I for use as the burial-tr nsit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? been signed by the atte should be detached for Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autons To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 NO Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 🗆 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anne

Powell

AUG 01 2011

Rebecca

31. Date filed (Month, Day, Year)

D72036

Medical Center Anna

Annapolis

			1 - For Amend Item 25 State Registrar	perme, ge	923,09/2	PP2012-dHb or F Certificate of D	ieaith and it Death	reg.	ne . N 2 0 1 1	25990
П	Physicia		Decedent's Name (First, Middle, La	enneth E.	 Wiedel			2. Date of Death	D, 2011 Year	3. Time of Death 1:35aM
	Medi Examir		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death	July 30	4c. County of Death	
			Holy Cross			Si	lver Spri	ng	Mon	tgomery
	Funeral Director		5. Social Security Number 578-28-6510 Usual Residence of Decedent	ex 7. Age	e (În yrs. last birtho 84 Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 09/23/1	9. Birth Cou	nplace (State or Foreign Intry) Nebraska
	and show 1 at	ō	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl 28a-f otified	irect	Maryland Prince	George's		Si	lver Spr	ing		1 Yes 2 X No
	with the is 23a or and the n	Funeral Director	10e. Street and Number 3148 Gracefield	Road, Apt.	. 522	10f, Zip Code	20904	10g.	. Citizen of What Cou	untry? S.A.
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	l by Fui	11. Marital Status 1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give	No 1944-	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ※ No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	, etc.
21215-0036	hours natura ical E	Completed by	15. Decedent's E	Year or Dates. ducation	1946	Decedent's Usual Occupa		166	b. Kind of Business I	hite
215	iin 72 e. han "r	omp	(Specify only highest gr Elementary/Seconday (0-12)	College (1-4 or 5	()	Give kind of work done d fe. DO NOT use retired)	uring most of worki	ng		
	d with Hygien ther th	Be C	17. Father's Name (First, Middle, Last)	5+		Credit Unio			I.S. Gover	nment
Maryland	be file ental l rked o ic eve	70		ph F. Wie	del		18. Mother's Name	e (First, Middle, Maid • Aqnes C.	Sponsel	
ary	19a. Informant's Name/Relationship (Type, Print) Lucille Therese Wiedel-Spouse 3148 Gracefield Road							l Route Number, City	y or Town, State, Zip	Code)
	nd 2 s lealth a m 27 i		Lucille Therese W	liedel-Spor	use 314	8 Gracefiel	d Road,#5	522, Silve	er Spring,	MD 20904
Baltimore,	permit. Page 1 a Department of I- Important: If ite any injury or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	cemetery,	Disposition (Name of crematory or other place Heaven Cen	e)		c. Location - City or T Luer Sprin	·
Balt	permit Depart Impor any in		21. Signature of Funeral Service vicens	de MOIE	2)	22. Name and Addres	s of Facility Hir Hampshire	ies-Rinala Ave., Si	li Funeral Lver Spri	.Home, Inc. ng, MD 20904
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line a. Ischemic	c Cerebr	al Vascular			MCA	Approximate Interval Between Onset and Death Days
-	Medical Examiner		resulting in death)	,	consequence of)	: Fibrillatio	10			Years
		ner	Sequentially list conditions, if any, leading to immediate		a consequence of)		YL			7 600 03
	outed nd rransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C				1	4	_ 3
092	leath certificate be executed eattending physician and dor use as the burial-transit	ledical E	resulting in death) Last	d	a consequence of)		Q	M APPROVED BY MEDI	CALEXAMINER	
687	rtificat ing ph e as th	/Mec	IF FEMALE:				CENTICATIO	M ALL		
Box 6	و کے ہ	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the common of the c	2 🗌 Fetal death	3 Ectopic pregnancy 5 Other (specify)	, , , , , , , , , , , , , , , , , , ,		23d. Date of deliver Month	very Day Year
s, P.O.	ires that the signed by t d be detach		Part II. Other significant conditions of Dementia, Old St		_	, -			co use contribute to	the cause of death?
ord	v require s been si should	Completed by	Disease, Commun	icatina Hu	drocepha	lus		24a. Was an		opsy findings available
Rec	The lav ate has oage 2	mo	o de de de de de de de de de de de de de					autopsy performed 1 \sum Yes 2 2	? death?	ompletion of cause of
Ea I	ysician: The la is certificate ha director, page 2		25. Was case referred to medical examiner?	11		26. Pla	ce of Death (Check		10 10	
ί	Physic this or	၉	1X Yes 2 X No 27. Manner of Death	Hospital: 1 XIInpatie 28a. Date of injur		atient 3 DOA Other	4 U Nursing Ho		e 6 Other (Specif	5/)
o L	ding l th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		ry work?	at Yes 2 \square No	28d. Describe how in	njury occurred	
Division of Vital Records,	l or Atten after deat Director: I in by the	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			, street, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
Ц	2 Accident 3 Suicide 4 Homicide 5 Could not be determined 5 Suicide 4 Homicide 6 Could not be determined 5 Suicide 4 Homicide 6 Could not be determined 5 Suicide 4 Homicide 6 Could not be determined 5 Suicide 4 Homicide 6 Could not be determined 5 Suicide 8 Suicid									ause(s) and manner stated.
	To th withir To th		29b. Signature and title of certifier	o i radionom lo mon	Social III Michigan	29c. License			Date signed (Month,	
	15+1			mich 85		D 00	65485	0	7/30/3	2011
_			30. Name and address of person who c			oe, Print)				
	Stat		Barbara Supanich 31. Date filed (Month, Day, Year)	KSM, MV, 3€. Registra	r's Signature 4	esi blen Ko	au, Silv	er sprung,	, mwigeani	20/10
	Registra	-	AUG 01 201	Cerous	r's Signature	arke				

23pt menty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1, per phy g919 9-21-11 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25991 Certificate of Death 1. Decedent's Name (First, Middle, Last) Zimita Weleteab 2. Date of Death 3. Time of Death Physician/ July Zamita Weleteab , 2011 ea 27 5:30a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 F 83 6/115/14 928 Ethiopia **Director** 577-17-8775 Usual Residence of Decedent 28a-f shov ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1534 Farlow Avenue 21114 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural" Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 be 1 unk. Bayeba Sabura Bayeba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Endale Atnafu/Son 1534 Farlow Avenue Crofton, Md. 21114 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Rega 4 ☐ Donation / 5 ☐ Other (Specify) Glenwood Cem. 7/30/2011 Wash.,DC 21. Signature and neral Service PHILIPADERINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? õ Month Day Year ed by the a detached f 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed? Yes 2 No this certificate 1 ☐ Yes 2 🔀 No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours af er death.

To the Funeral D rector, Affe Natural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of celtifier son who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 26, Day 2011 Year Physician/ Hongyu Xu 4:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 3222 Winmoor Drive Ijamsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) China Hours Sept. 3, 1944 1 X M 2 - F 241-47-7781 66 Yrs **Director** Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Ijamsville Frederick 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be Funeral United States 3222 Winmoor Drive 21754 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. δ Maryland 21215-0036 1 Tes 2 X No Specify: Specify: Asian 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturny injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computers Engineer Be 17. Father's Name (First, Middle, Last) (unk.) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) ರ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Winmoor Drive, Ijamsville, MD 21754 Weiwen Zhao / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Kesthaven
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 2011 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Fun Service Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only or ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Onset and Immediate Cause Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) *i*xaminer Sequentially list conditions, Examine Due to (or as a consequence oi): it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events o the Hospital or Attending Physician; The law requires that the death certificate be executed -tran and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No. the page 2 should be detached Unknown g 🔲 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X**010 Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State)

within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to within 24 hours

> State Registrar

Medical

29a. Certifier (Check

29b. Signature and title

Name and address

31. Date filed (Month, Day

of death (Item 23a) (Type, Print)

strar's Signature

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32. Reg

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1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Por State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUSTI Physician/ Day Month 2011 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Zelli Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country)

VA **Funeral** Date of Birth 1 □ M 2 🏋 F Days 230-22-9276 84 MOUT 424 926 Director Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director M) n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Introduction: If it was 1 and was a marked other than "natural", or items 23a important: If item 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must bo 3128 Normount Avenue 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: African-American 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Cobbler Dundalk Shoebuilding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Lockett Rosa Anna Lockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Collins/ Daughter \$154 Stafford Road, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 8-18-2011 King Memorial Park Woodlawn, MD 21. Signature of Europal Service License 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, MD 21133 Pur 1. Enter 1st: dise 1st, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ merceaua disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Celau Caucer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death be detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No 1 Yes Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပု Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 No filled in by the Accident Investigation Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Attellaction 30 Name completed cause of death (Item 23a) (Type, Print) and address of person 31. Date file (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

. #1	1. Decedent's Name (First, Middle, Las	t)		2	2. Date of Death	Day Voor	3. Time of Death
	Carol Virginia E	Baber		6	luguet "	7 2011	2:50 AM
	4a. Facility Name (If not institution, give	street and number)			-	4c. County of Death	1
sa:	Roland Park Plac	e					
	1	Class 657 =	Months Days	Hours Min. D	B. Date of Birth (Month, Day Yea	9. Birth	place (State or Foreign WYork
	224-58-6587	82	Yrs.	ре	ec 25, 19.	ZO NE	W IOLK
	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
ō	MD	Bal	timore				1 Yes 2 □ No
rect			10f. Zip Code		10g, (Citizen of What Cou	intry?
al Di	830 W. 40th St;	Apt 509	2121	1		USA	
ıner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Speci	fy Yes or No- ican, etc.)	14. Race - Ameri	
F	1 X Never Married 2 Married	1 ☐ Yes 2 ሺ No If Yes, Give	1 □ Yes 2 X No		, , , ,	747	hite
d b		Year or Dates:			Tim	Estate tra mes	
lete	15. Decedent's Ed (Specify only highest gra	ucation 16 de completed)	Give kind of work done	pation during most of working	7 1		*
E G	Elementary/Secondary (0-12)	College (1-4or 5+)		,			
ပ္သ		2	administrat				
B		Baber		1		,	
ĭ	19a. Informant's Name/Relationship (*)	Type. Print) 1					
	Jacqueline Hild	ebrand - sister	440 Waggama	n Cir; Anna	apolis, M	Maryland :	21403
	20a. Method of Disposition	ceme	of Disposition (Name of etery, crematory or other pla		te 20c.	Location - City or 1	Town, State
				1			
	21. Signature of Funeral Service Licer	see//-/					
	Janualle	lle	655 W. Ba	ltimore St.	.,Baltimo	re, MD 2	1201
	23a. Part . Enter the disr ase, or com shoot or heart failure. List only	plications that caused the death. Done cause on each line.	o not enter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
85. U	Immediate Cause (Final disease or condition	. End- Stage.	alsheimer's	disease	,	3	Onset and Death
	resulting in death)	Due to (or as a consequence					•
_	Sequentially list conditions,	b					
ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce or):				
хап	that initiated events resulting in death) Last	c	ce of):				
			,				
	,	d					
/Me	IF FEMALE:	23c. If yes, outcome pf pregnancy				23d Date of deli	verv
ciar	in the past 12 months?			cy		Month	Day Year
hysi	9 Unknown	9□Unknown					
γP	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause given	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
g p					1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
lete					24a. Was an	24b. Were au	topsy findings available
mo					performed	? death?	completion of cause of
	25. Was case referred to medical			26. Place of Death (10 10165	2 140
.0 B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA Oth	hor		e 6 □Other (Spec	cify)
n: T	27. Manner of Death		b. Time of 28c. Inju				
atio	2 ☐ Accident Investigation						
tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	28			ıral Route Number,
ical	(Check only 2 Medical Exam	niner: On the basis of examination	dge, death occurred at the to and/or investigation, in my	ime, date and place, ar opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Med		and manner stated.	29c Licens	se number	204	Date signed (Mont)	h Day Yourl
		ac freguen					
	, activity !	' /				Jun 3	10011
		completed cause of death /lies- 00	a) /Typo Print)			-	
	7. Is AS ELLE	completed cause of death (Item 23)	a) (Type, Print)	et Back	mare, Mo	121211	
	Medical Certification: To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director	Carol Virginia E 4a. Facility Name (If not institution, give Roland Park Place) 5. Social Security Number 6. St. 224-58-6587 1 Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 830 W. 40th St; 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra 12 17. Father's Name (First, Middle, Last) John Lafayette 19a. Informant's Name/Relationship (I Jacqueline Hild 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Monation 5 Other (Specify 21. Signature of Funeral Service Licen 23a. Part Enter the dist ase, of compshoothing in death) 19a. Uniform products Cause (Final disease or condition resulting in death) 25b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Other (Specify 1) Per St. 19 Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Other (Specify 1) Per St. 19 Was decedent pregnant in the past 12 months? 19 Was decedent pregna	Carol Virginia Baber 4a. Facility Name (If not institution, give street and number) Roland Park Place 5. Social Security Number 224-58-6587 Security Number Security	Carol Virginia Baber 4a. Facility Name (If not institution, give street and number) Roland Park Place 5. Social Social Social Society Number 2 2 4 – 58 – 65 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore 10c. Street and Number 830 W. 40th St; Apt 509 11. Marital Status 12. Was Decedent Feer in U.S. 13. Was Decedent Feer in U.S. 14. Was Decedent Feer in U.S. 15. Decedent's Education (Specify only highest grade completed) 12	Carol Virginia Baber 4. Fealthy Name (If not institution, give street and number) Roland Park Place 5. Social Security Number 2.4 - 58 - 6387 March Security Number 6. Sex 1	Carol Virginia Baber Carol Virginia Baber Carol Virginia Baber Carol Virginia Baber Ab. Clip, Town, or Location of Death Baltimore Roland Park Place S. Social Security Number 224-58-65587	Carol Virginia Baber Carol Virginia Baber Carol Virginia Baber Carol Virginia Baber Color Section of Death Roland Park Place Social Security Name Social Security Name Color Section of Death

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 26 per verb., g918,08/16/2011dhb Certificate of Death 25995 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Beasley Month Donna 6:38 P^M 2011 <u>August</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rising Sun 2210 Principio Road Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 57 Days 1 □ M 2X F Months Hours 265-21-0807 04/17/ Yrs Director DC Usual Residence of Decedent 28a-f shov aţ 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ler must be notified Cecil MD Rising Sun 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Mushroom Lane 21911 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 XYes 2 No Army
If Yes, Give Year or Dates. 1972-74 Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify White Specify. "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked or မ Kittridge James Beasley Barbara other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 Principio Road, Rising Sun, MD Caroline McGrady/Daughter 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once. Final Journey Crem. 8/10/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Renal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 8 9 Unknown Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? b Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director; After this certificate to completed filled in by the funeral director, page. 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Daughter's Residence Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

DHMH 17 Rev 7/2009

State Registrar (Check

29b. Signature and title of certifier

31. Date filed (Month Day, Year) AUG 1 6 2011

MSRyapaliseM.O

N.S. Rajapa KSE, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Snith AV 5-203

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

00057465

29d. Date signed (Month, Day, Year)

815/11

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 25996 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Year August 15, Physician/ Ruth Blachowicz 4:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Davs Hours Min 236 58 5534 72 Director 1 □ M 2 🛣 F Vrs 09/29/1938 West Virginia 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director notified 1 Yes 2 No Baltimore Essex Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be n Funeral 1402 "A" Browning Drive 21221 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 XNo 9 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 ₩ Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own home Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked of rother traumatic even ည Robert Marion Jones Hattie Lena Mashburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 701 "B" Snowberry Court Essex Maryland 21221 Bonnie Torres (daughter) 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🗶 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 8/16/2011 | Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA are of Ineral Service Licenses 1407 Old Eastern Avenue Essex Maryland 21221 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MOTASTATIC HEAD AND NECK CAM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if dry, leading to intrically cause. Enter Underlying Cause (Disease or injury that initiated events Dusi to (or as a consectionne of) Examine the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ō in the past 12 mont Month Dav Pregnant at time of death be detached the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaco use contribute to the cause of death? <u>۾</u> 2 DIABETES MELLITUS 2 No 3 Probably 4 Unknown Completed HROWIC OBSTEUCTIVE PULLWONARY DISONE Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No hours after death. Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25997 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Augustus Benton August 10:51 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2 Crismers Court Road Gwynn Oak Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 242-28-9410 1**X** M 2 □ F Months Hours Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Gwynn Oak 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Crismers Court Road 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces:

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify African-American Completed 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Locke Insulators Bricklaver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Hixie Pickett Augustus Benton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendi N. Redfern/Granddaughter 214 Midpine Court, Owings Mills, MD 21117 20a. Method of Disposition

1 🖸 Burial 2 🔲 Cremation 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3 Removal from State Garrison Forest Veterans 8-22-2011 Owings Mills, MD 4 Donation 6 Oth 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 2000 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician/ **Examiner Funeral** Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once. Baltimore, Maryland 21215-0036 Physicism/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and r attending physician Division of Vital Records, P.O. Box 68760 ate has been signed by the atte page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? this certificate 2 No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one examiner? Other 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. bescribe how injury occurred Natural Accider 5 Pending 1 Yes Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat nd title of dertific Q Date filed (Mo State

Registrar

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Winfield Scott Bayer 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Square Hos Rosedale Franklin If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Months Hours Min. Mary Land 75 Director 217-30-3278 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Maryland notified at rector 28a-f Md Balto Perry Hall ö 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral USA 4421 Forge Road 21128 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural", Completed 3 ♥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) be filed within College (1-4 or 5+) Freight 12th Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilhemia Smith Charles Bayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bayer Abingdon, Md. 21009 <u>Cynthia Harris</u> 2637 Smallwood Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills 8-16-2011 Middle River, Md. Schimunek Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Due to (r as a consequence of): icator Medical resulting in death) **Examiner** umoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
24 hours after death.
5 Funeral Director: After this certificate has been signed by the attending physicis leted filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MetaStatic Small Cell Lung Completed 24a Was an autopsy performed completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 **N**0 ပ 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of injury (Month, Day, Year)

ettiar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 0000 9000 Franklin Square Drive Baltimore, MD 21237

05 PM

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

Year

White

1 ☐ Yes 2X No

State Registrar

Certificate:

Medical

27. Manner of Death

1 Natural

☐ Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check

only one

29b. Signature and title of certifie

Juston

Sundaram

5 Pending

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

To the I within 2

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

29c. License number

work?

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene.

			1 - State of Maryland / Department of the Registrar Cert	ificate of Death		Reg. No.	25999
	Physicia Medic	TOTA DECACE			2. Date of De Month Aug •	14 ^{Day} 201 ^{Ye} qar	3. Time of Death 11:25рм
	Examin		4a. Facility Name (if not institution, give street and number) Heritage Center	4b. City, Town, or Locatio Baltimor		4c. County of Dea Baltin	
Ī	Funeral Director		5. Social Security Number 2 1 7 - 26 - 3 1 0 1 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Und Months Days Hours	er 24 Hrs. 8. Date of Bir Min. (Month, Da NOV • 1	th 9. Bi gy, Year) 9. 9 9, 1929	rthplace (State or Foreign ountry) MD
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ath with the Maryland ems 23a or 28a-f show r must be notified at	Funeral Director	7232 German Hill Road	10f. Zip Code 21 222	Origin? (Specify Yes or No- Dan, Puerto Rican, etc.)	10g. Citizen of What C USA 14. Race - Am	
	nin 72 hours after de ne. than "natural", or it e Medical Examine	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4X ☐ Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) War if Yes 2 XNo If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 XNO If Yes 2 X	Yes, specify Cuban, Mexic Yes 2 No Specient's Usual Occupation Ind of work done during many of NOT use retired) Yes S	ify:	Specify:	White
land 21 be filed with ental Hygier ked other t		To Be C	9th Walte 17. Father's Name (First, Middle, Last) Samuel Hanke		other's Name (First, Middle,	, Maiden Surname)	
Maryla 2 should b th and Me	2 should Ith and M 27 is mar r traumati		19a. Informant's Name/Relationship (Type, Print) Curtis Betzel /son 19b. Mailing 290	g Address (Street and Num 12 W. Fran)	nber or Rural Route Number		
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Dongton 5 Other (Specify)	ition (Name of temor other place)	8/17/11	20c. Location - City o	
Baltı	permit. Page 1 a Department of I- Important: If ite any injury or ot		holes fly morely h.	Name and Address of Fac	ly Funeral	e Ave. Ba Home of	lto. MD Essex 212 ₂₁
	Pnysician/ Medical Examiner	ıminer	23a. Part 1. Enter the disease, promplications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury)	C-CAKDION	as cardiac or respiratory at ASCULAR D RTENSO	SISEMSE	Approximate Interval Between 2015 and Death A
09/89 X	tending physician and ruse as the burial-transit	Physician/Medical Examiner		Ectopic pregnancy		23d. Date of d	· ·
.O. BOX	v requires that the death certi been signed by the attendin should be detached for use s		1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	Other (specify)	art I. 23e. Did t	Month	Day Year o the cause of death?
rds, r.	equires the	eted by			1 🔽	Yes 2 □ No 3 □ I	Probably 4 Unknown
Vital Records,	ician: The law recertificate has breetor, page 2 st	Completed			1 🗆 Yes	psy prior to death?	completion of cause of
DIVISION OF VITAI RECORDS, F.O. BOX To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendent filled in by the funeral director, page 2 should be detached for	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	To B	25. Was case referred to nedical examiner? 1	Other	_	dence 6 Other (Spe	cify)
DIVISION	rtal or Atte	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (City or To	Street and Number or Ri wn, State)	ural Route Number,
	To the Hosp within 24 hou To the Funer completed fill	Medical	29a. Certifier (Check only one), 2 Medical Examiner: On the basis of examination and/or investigation of the basis of examination and investigation of the basis of examination and investigation of the basis of examination and investigation of the basis of examination and investigation of the basis of examination of examination of the basis of examination	gation, in my opinion, death	ate and place, and due to the	and place, and due to the	cause(s) and manner stated. s stated.
			30. Name and adoless biperson who completed charge of death (Item 29a) (Type, Pr	IN UM - A	PITCHI	AUG. 14	BAITMOR
)V	Stat	0	31. Date filed (Month, Day, Year)	92 LAND	2 12 25		- ALITON A
	Stat Registra		AUG 1 6 2011 June 2. Law	les !			

			_ State	Maryland / Dep	artment of F			iene _{eg. N} 2011	26000
			Registrar 1. Decedent's Name (First, Middle, Last)		rimouto or E	- Catri	2. Date of Deat	h	3. Time of Death
	Physicia Medio		Robert Glenn Brace	Augi			ugust 10, 201 4:00 PM		
Examiner 4a. Facility Name (if not institution, give street and number)			er)	4b. City, Town, or		ath	4c. County of Deat		
	Fundament		5693 Scarlet Court 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Mount	Airy I If Under 24 Hi	rs. 8, Date of Birth	Frederic	k hplace (State or Foreign
	Funeral Director		384-32-5324 1 M № 2 □ F	77 Yrs.	Months Days	Hours Mi) 1934 Mic	higan
	d Iow	L	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	contion				404 114- 01-11-14-
	arylan a-f sh ified a	Director	Maryland Frederick		Airy				10d. Inside City Limits 1 ☐ Yes 2X No
	the M or 28 e noti	Dir	10e. Street and Number	Tiodire	10f. Zip Code		1	0g. Citizen of What Co	untry?
	s 23a rust b	y Funeral	5693 Scarlet Court		2	1771		United Sta	ites
	r item iner n		11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S. 13. es?	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
920	s after ral", o Exam	ed by	1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never 2 If Yes, Give 3 Widowed 4 Divorced Year or Date:	□ No s. 1952–79	1 ☐ Yes 2 🔀 No	Specify:		SpecifyWhit	e
2-0	2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	. Decedent's Education 16a. Dec			orkina	16b. Kind of Business Industry	
121	thin 7; ene. than)om	Elementary/Seconday (0-12) College (1-4	or 5+) life. L	kind of work done done do NOT use retired) ief Petty	-		Jnited Stat	es Navv
р 5	led wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, Last)	CII.	Tel Telly		ame (First, Middle, N		CB Mavy
ylan	ld be fi Mental arked atic ev	입	Gerald W. Brace			Della A	Alberti		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy order to other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn L. Brace / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5693 Scarlet Court, Mount Airy, MD 21771						Code)
ore,	e 1 an t of He If item or othe		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from St	20b. Place of Disponent	osition (Name of matory or other plac	Θ) Δ110	Date 17,	20c. Location - City or	Town, State
<u>Ħ</u>	t. Pag rtment rtant: njury o		4 Donation 5 Other (Specify)	Memoria	matory or other place laven Lavenstardens	Aug	2011	Frederick,	Maryland
Ba	Depar Impo any it		21. Signature of Intral Survice Lice see					, Skkot Cod , Frederick	
			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each					st,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disea						cer		Onset and Death	
		iner	Sequentially list conditions, if any Lading to immediate cause. Enter Underlying	as a consedience of:					
g Cause (Disease or iinjury that initiated events c.									
	be exe sician a burial-	dical E	resulting in death) Last Due to (or	as a consequence oi).					
2.09	ficate g phys	1edio	d						
89 x	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes 1 □ I ive Bir		Ectopic pregnanc	v		23d. Date of del	very
No of the factor						Month	Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					acco use contribute to	se contribute to the cause of death?			
						es 2 No 3 🗆 Pr	No 3 Probably 4 Unknown		
CO	law red nas ber e 2 sho	Completed					24a. Was ar autops	y prior to d	opsy findings available completion of cause of
						ned? death? No 1 \(\subseteq \text{Yes} \)	1? Yes 2 □ No		
Ita	Physician: r this certific ral director,	100	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Otho	ce of Death (Ch			_
5	Ph alchiis	te: To	27. Manner of Death 28a. Date of i		f 28c. Injury	at	28d. Describe ho	nce 6 Other <i>(Speci</i> w injury occurred	fy)
0	Attending er death. ector: After by the funer	ifica	2 Accident Investigation	Day, Year) injury	M 1 🗆	Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No							and Number or Rural Route Number, ate)		
	To the Hospital or within 24 hours aftu within 24 hours aftu To the Funeral Dir completed filled in	edical	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of	of examination and/or inves	stigation, in my opinio	n, death occurre	d at the time, date and	d place, and due to the o	ause(s) and manner stated.
\	To the within To the Comple	Σ	only one) 3 ☐ Certifying Nurse Practioner: To a 29b. Signature and title of certifier						
			Nanyaten, m.D		053	7070		8/16/2	-1/
1	DO.		29b. Signature and title of certifier NAMAN (M.) 30. Name and address of person who completed cause of Dan Lancau MD	of death (Item 23a) (Type, I	Print) ANS St	B41	hower	MD 2/2	231
	Stat	e	31. Date filed (Month, Day, Year) 32. Jegi	strar' Signature	•			-	